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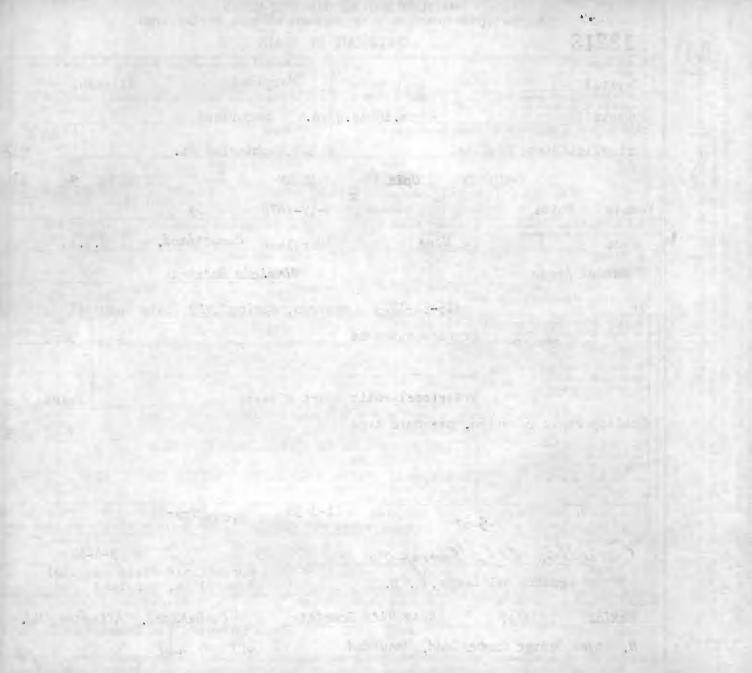
HOSPITAL Page 4 FUNERAL

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12218 12229 CERTIFICATE OF DEATH O HOSPITAL OR ATTENDING PHYSICIAN: THe law requires that the death certificate be executed within 24 hours after death. the funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). o. SIAIE Maryland b. COUNTY Allegany o. COUNTY Carroll MARYLAND in by the fars. Pages 2 hours afte b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)

Sykesville c. CITY DR TOWN (If outside corparate limits, write RURAL and give nearest town) E. LENGTH OF STAY IN 16 30vrs. 10mos. hdvs. Cumberland d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS 408 Washington St. NO X SpringfieldState Hospital 3. NAME OF Middle 4. DATE campletely Year DECEASED MARGARET Opie. ANNAN SEPTEMBER Type or pnnt) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS SEX 6. CDLOR OR RACE DATE OF BIRTH 9. AGE (In years NEVER MARRIED 7. MARRIED 8 dost birthdoy) Months White 6-19-1878 Female ar remaval, and in any WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

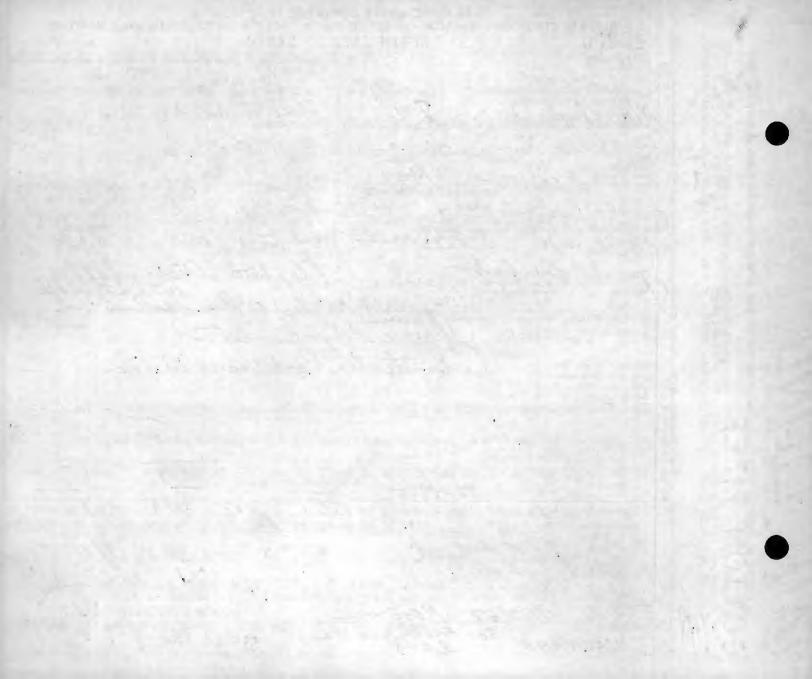
None 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT None COUNTRY? Cumberland. Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Daniel Annan Virginia Butcher IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give wor or doles of service) 215-56-1383 Records, Springfield State Hospital INTERVAL BETWEEN ONSET AND DEATH Days 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) signed by the burial-transit PART I. DEATH WAS CAUSED BY: Bronchopneumonia IMMEDIATE CAUSE (o) DUE TO burial, Conditions, if ony, which gove (b) rise to immediate couse (a). DUE TO stating the underlying couse Health priar ta Arteriescleretic heart disease Years PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) SCHIZOPHTENIC reaction, paranoid type 19. WAS AUTOPSY PERFORMED? NO K 20b, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING [3] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME DF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. factory, street, office bldg., etc.) Not While of work at work **DIRECTOR:** After 21. I certify that (1) (this hospital) attended the deceased from 11-2-36 , that (I) (we) last 50PM, from causes and an the date stated above saw the deceased alive on 9-5-67 and that death accurred at 22b. DATE SIGNED **ATTENDING** X 9-6-67 director, page 3 shauld be filed v DIRECTOR 22d. ADDRESS Springfield State Hospital TO FUNERAL (ME (Type) Agustin del Campo. M. Sykesville, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230. BURIAL, CREMATION, 23b. DATE THEREOF (County) (Stote) EMOVAL (Specify) Rose Hill Cemetery Cumberland 9/8/67 Allegany Md. ADDRESS 250. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR DATE SEP H. Wayne George Cumberland, Maryland 8 1967 25M 1/67



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12213 12230 CERTIFICATE OF DEATH 24 haurs after death. pup attending physician and campletely filled in by the funeral permit. Then please remave carbon papers, Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY **B. COUNTY** Marvland Carroll MARYLAND b. CITY OR TOWN (If autside carparate limits, CLENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) write RURAL and give nearest town)
Sykesville Baltimore 2 vrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 3905 Oakford Avenue Springfield State Hospital YES NO X requires that the death certificate be executed within NAME OF Middle 4. DATE First Year DECEASED OF JAMES PURVISS ARTHUR Type or print DEATH S. SEX 9. AGE (In years IF UNDER I YEAR IF UNDER 24 HRS 6 COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED last_birthday) Months Davs Hours 03-05-12 Male Negro DIVORCED and in any WIDOWED 10a. USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY South Carolina U.S.A Laborer 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME remayal Elizabeth Taylor, deceased Rubin Arthur, deceased 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT permit. (Yes, na, ar unknawn) (If yes give war ar dates of service 20 226-18-4220 Hospital Records No OD. 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p cremat PART I DEATH WAS CAUSED BY ONSEL AND DEATH Huntington's Chorea. IMMEDIATE CAUSE (o) DUE TO months Canditians, if any, which gave Toxicity due to infected decubitus ulcers. rise to immediate cause (a), DUF TO stating the underlying cause by the haspital ar attending the has been last. SD PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CBS as or, with diseases of unknown or uncertain causes. Huntington's 19. WAS AUTOPSY PERFORMED? for use YES TO chorea, without qualifying phrase. Parkinsonism. NO certificate 20g. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH be detached State Dept. af (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Harne, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year Hour a.m. factory, street, affice bldg., etc.) Not While director, page 3 should be d al wark 21. I certify that (I) (this haspital) attended the deceased from . 19_67, that (I) (we) lost be retained and that death occurred at 205 M. from couses and on the date stated above. sow the deceosed olive on 9-15-67 19. 22b. DATE SIGNED 22a. SIGNATURE MED. DIRECTOR STAFF PHYS. **ATTENDING** 9-16-67 PHYS 22d. ADDRESS 4 may ATONCHERE Springfield State Hospital, Sykesville NAME (Type) director, should be 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, or Town) (State) BURIAL, CREMATION. (County) REMOVAL (Specify) IVAR ADDRESS 25g. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR-VR A15 (4) 20 M 1/66 DATSEP TON

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Page	shou	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town of county) (State)
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13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME	
John M. Baumgardner	Pearl M. Fritz	
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15/9-05-693	36 Mrs. Margie McClenagha	m lt. Arry. 111
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NAME (Type) XI. Glein Spelcher	Address Steel Marin Scounty)	
NAME (Type) M. Glein Society 230 BUR AL (REMATION, 236 DATE THEREOF 23c. NAME OF CEN	METERY 23d 10CAT ON 16th of I	
NAME (Type) XI. Gle in Spolcher 230 BUR AL (REMATION, 23b DATE THEREOF 23c. NAME OF CEN 7 REMOVAL (Specify) 9/04/1967 Pine Gro	AFTERY OF CL. SON STORY OF LICE AIR VILLE STUDEN	ille Carroll
NAME (Type) W. Glein Snolcher 230 BUR AL CREMATION 236 DATE THEREOF 23c. NAME OF CEN	AFTERY OF THE SOLUTION OF THE	



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12223 CERTIFICATE OF DEATH . 2237 requires that the death certificate be executed within 24 hours after death the attending physicion and completely filled in by the funetal sit permit. Then please remove carbon papers. Pages 1 and nation, or removal, and in any event, within 72 hours after deal 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) I PLACE OF DEATH o. COUNTY a. STATE b. COUNTY Carroll Allegany Maryland MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURA), and give nearest town)

Rural—Sykesville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 15 Cumberland ly. 9m. ld. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO Springfield State Hospital 10 Massachusetts Avenue 3 NAME OF Middle Year Day DECEASED 18 19 67 Janat Louise Bealky DEATH (Type or print) IF JNDER 1 YEAR IF UNDER 24 HRS. S SEX 6 COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED T 25 rthdoy) Days Hours 5/20/42 white female WIDOWED DIVORCED 12 CITIZEN OF WHAT 10g USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? INDUSTRY Maryland -Cumberland USA none 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Ella Davis Robert Mealky, Sr. 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) Springfield Hespital records, Sykesville, Md. no none NTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) signed by the burial-tronsit puriol, crematic ONSET AND DEATH PART I. DEATH WAS CAUSED BY. Pneumonia IMMEDIATE CAUSE (a) DUE TO Toxemia due to infected decubitus ulcers weeks Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying cause TO FUNERAL DINICTOR: After this certificot his been as the 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) YES 🛶 NO deficiency, idiopathic, severe, with behavioral reaction, Poge 4 moy be retoined by the hospital or Į0 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) 200 ACCIDENT WAS UNDERLY NG [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20s. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Dov. Year factory, street, office bldg., etc.): Not While ot wark at work 9/18/__, 19 67, that (# (we) last 21. I certify that (# (this haspital) attended the deceased fram. . 19.65 , ta_ 1967, and that death accurred at 6215 M. from causes and an the date stated above 9/18/ saw the deceased alive on_ 22b. DATE SIGNED 22g. SIGNATURE ATTENDING 9/18/67 diane DIRECTOR director, page 3 should be filed v Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Edmee J. Reeves, M. D. Sykesyille Maryland 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230 BURIAL, CREMATION, 23b. DATE THEREOF BUREMOVAL (Specify) Sunset Memorial Park Cumberland, Md. Allegany Sept.21.1967 James F. Scarpelli, Cumberland, Md. 250 SEF DBY REGISTRAR 5 SIGNATURE 24. FUNERAL DIRECTOR **VR A15 (4)** 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12224 12235 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived of institution Residence before admission) o. COUNTY o STATE 6 COUNTY Carroll Carroll bon papers. Pages 1 within 72 hours after MARYLAND completely filled in by the fance tarbon papers. Pages b City OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester 5 Months Millers d STREET ADDRESS e. IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Longview Nursing Home Inc. Rt. YES NO SE 3 NAME OF Middle First Lost DATE Month DECEASED (Type or print) Dennis Gilbert e a Beers Sept. 15. 19 67 DEATH IF UNDER 1 YEAR LIF UNDER 24 HRS SEX 6 COLOR OR RACE 8 DATE OF BIRTH 9 AGE (In years 7. MARRIED [38] NEVER MARRIED remove lost birthdoy) Months Hours Male White WIDOWED DIVORCED March 5, 1903 physician and c 1Do. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHP_ACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT signed by the attending physician on burial-transit permit. Then please re burial, cremation, == remaval, a==| in+ COUNTRY? Electric Tools during most of working-life even if refired) Henryville Ind. 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Gilbert S. Beers Capoline King 17 INFORMANT Address IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, grunknown) (If yes give wor or dotes of service 213-09-3219 Mrs. Margaret Beers Millers, Md. 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) by the haspital ar attending physician. Colon - Metactuers DUE TO Conditions, if ony, which gove rise to immediate cause (a), DUE TO storing the underlying couse has been 3 should be detached far use as the with the State Dept. of Realth prior to 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO P TO FUNERAL DIRECTOR: After this certificate director, page 3 should be detached for us should be file!! with the State Dept. of "easts. 20o. ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 2Dc. TIME OF INJURY Month, Doy, Year Haur o.m. foctory, street, office bldg., etc.) Not While of work O HOSPITAL OR ATTENDING . 1961, that (I) (we) lost 21. I certify that (I) (this hospital) attended the deceased from 196 0 Page 4 may be retained and that death occurred at CTO M, from couses and an the date stated above. saw the deceased glive an_ 22o, SIGNATURE 22b. DATE SIGNED MED. DIRECTOR ATTENDING M.D. 22c. PHYSICIAN'S 22d. APDRESS reumpen NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION, 23b DATE THEREOF 23d. LOCATION (City of Town) Bu REMOVAL (Specify) Sept. 18. 1967 Oaklawn Cemetery Baltimore City Md. 2Sb. REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR **VR A15** Tipton - Eline Funeral Home Hampstead. Md. 20 M 1/66



1	ı	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2121	11
FOR STATE		4.000 (c)	2235
HEALTH DEPT.	1	PLACE OF DEATH o. COUNTY Carroll MARYLAND D. CITY OR TOWN (If outside corporate mits and content of the con	,
der der M3 M3 M3 M3 M3 M3 M3 M3 M3 M3 M3 M3 M3		b CITY OR TOWN (If outside corporate mits write RJRAL and give write RURAL and give nearest town) Rural - Sykesville Lyr. 8 mos Westminster,	neorest town)
form P. form P. form P. form P.		d NAME OF HOSP TAL OR INSTITUTION (If not in haspitol, give street oddress) d STREET ADDRESS	e S RESIDENCE ON A FARM?
_ 8 4 4 5 7 5	3	Springfield State Hospital Route # 7 Box 295-B NAME OF First Middle Lost 4 DATE Month	VES NO Dov Year
offer deoth 1f as 8 Give Pages 1, 3 olong with farm with the Stote Dep within 72 hours o	Ĺ	DECEASED OF (Type or print) JOHN THOMAS BLANCHARD OF DEATH September	
ofte olon with		SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 AGF (In yeors lost b rithdory) 77 vrs Male Widowigh Divorced 9-17-1890 77 vrs	YEAR IF UNDER 24 HRS Days Hours Min
1. 24 hours In Item Item Item Item Item Item The strict of	du	USUAL OCCUPATION (Give kind of work done industry) Stationery Engineer Chemical Co Baltimore, Maryland USA	ZEN OF WHAT VTRY?
F E E E E		FATHER'S NAME William Blanchard Hargaret Shelby	1
in pe	1	WAS DECEASED EVER IN U.S. ARMED FORCES? So, no, or unknown) (Iff yes give wor or dotes of service) No 215-03-2618 Redords. Springfield State Hospit	
executed nding" in Medical 1 permit. I	L		
in in in		18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Bilateral branchopneumonia The property of the pro	INTERVAL BETWEEN ONSET AND DEATH days
sert.ficote should writing the word rwarded to the Ch sed os o burral-tra sed is cemotion,		Conditions, if any, which gave) itse to immed ofe couse (o), stating the underlying couse (b) Healed myocardial infarct. DUE TO	months
firot fing irded os c al, cr		(c) Coronary arteriosclerosis	vears
MER: This cert.ficote e certificate, writing thishould be forwarded to files. 3 should be used as a birt, prior to burial, cren	CERTIF	PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) Healed fracture of head of right femur. Chronic brain syndrome with senile brain disease with psychotic reacti 200 EXTERNIA CALSE WAS PRIMARY TO OF CONTRIBUTING CON	PERFORMED? YES X NO
EXAMINER: ute the cert oge 4 should your files. Poge 3 should ed agent, pr	MEDICAL	20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form Hour om. While of work of work of work 19 o	ty) (State)
AL EXA EXECUTE F. Page I for you TOR: Page		21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , death resulted fram. Natural causes , Accident , Suicide , Hamicide , Undetermined monner	and in my opinion
O DEPUTY MEC. AL EXAMINER: This necessory, please execute the certificate the funeral director. Poge 4 show d be 5 may be retained for your files. O FUNERAL DIRECTOR: Poge 3 should be Health or its designated agent, prior to		ACTUAL SIGNATURE DESCRIPTION ASSISTANT MEDICAL EXAMINER D	22. DATE SIGNED
o DEPUTY necessory, is the funeral s may be r o FUNERAL Health or its		EXAMINER'S NAME (Type) W. Glenn Speicher, M. D. Deputy Medical Examiner Agress (See Gy App Deputy)	211/1
TO DEPU necesso the fun 5 may TO FUNE	230		Enrolling
VR A15ME (A)		FUNERAL DIRECTOR ADDRESS OF GEODE - LOOL Ritchie Hewyl Baltimore OF SEP 2 5 1967	NATURE



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH corpor papers. Pages 1 and 2 and 2 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. Carroll °Maryland Carroll MARYLAND the attending physician and campletely filled in by the sist permit. Then please remave corbon papers. Pages b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 1b Hampstead 10 mo. 19 da. PHYSICIAN: The law requires that the death certificate be executed within 24 haurs d. STREET ADDRESS e IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) ON A FARM? Springfield State Hospital 16 South Main Street YES 🗌 NO 30 3 NAME OF Middle 4 DATE Year DECEASED Blizzard 67 September Harry Luther DEATH 19 IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX B DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** birthdoy) Davs Hours 9-12-1882 WIDOWED Ma⊥e White DIVORCED 100 US_AL OCCUPATION (G ve kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12. CITIZEN OF WHAT during most of working ite, even if retired) COUNTRY? INDUSTRY USA Maryland Carpenter retired Carpentry 13 FATHER S NAME 14 MOTHER'S MAIDEN NAME ar remaya Mary Ann Belt John Wesley Blizzard IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) 217-12-1924 Springfield Hospital Records 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
Tobar Dreu INTERVAL BETWEEN burial-transit ONSEL AND DEATH Lobar pneumonia IMMEDIATE CAUSE (o' signed by DUE TO Chronic mitral heart disease Conditions, if ony, which gove vears rise to immediate couse (a). DUE TO stoting the underlying couse be retained by the hospital or attending Page 4 may be retained by the hospital or attending O FUNERAL DIRECTOR: After this certificate has been as the 19. WAS AUTOPSY PERFORMED? PART 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) be detached for use State Dept. af Health CBS associated with Senile Brain Disease with psychotic reaction NO 200. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Not While of work at work . 19 65 that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased from 8-20-19 65, to 9-7shauld 1965, and that death accurred at \$25PM, from causes and on the date stated above. saw the deceased alive an 9-7 22b. DATE SIGNED 22o. SIGNATURE STAFF PHYS. 9-8-67 X director, page 3 should be filed v M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN S Springfield State Hospital Heinz NAME (Type) Maatsch. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b DATE THEREOF (Stote) (County) 230 BURIAL, CREMATION, Butter (Specify) Hampstead Carroll Co. Md. Sept. 10. Shiloh Cemetery 25o. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR Mariley Judge VR A15 (4) Tipton - Eline Funeral Home Hampstead, Md. 20 M 1/66



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH hours after PLACE OF DEATH 7. USUAL RESIDENCE (Where decessed lived, if Institution, Residence before edmission) a. COUNTY b. COUNTY Carroll Maryland Carroll MARYLAND \$ 7 7 b. CITY OR TOWN (if outside corporete limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) v c. LENGTH OF STAY IN 16 write RURAL and give nearest town) Rural Taneytown Rural Taneytown ,⊆ hours aft d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? YES T NO Route papers. completely The law requires that the death certificate be executed 3. NAME OF First DATE Dev Midd e Lest Month DECEASED OF (Type or print) Mamie Esther Bollinger DEATH 196 and cor 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Years | IF UNDER 1 YEAR 5. SE 8 DATE OF BIRTH AGE (In IF UNDER 24 HRS. £i¥ last birthday) Months | Devs Hours March 1. White WIDOWED [DIVORCED TO Female physician 10a. USUAL OCCUPATION (Give kind of work 10b, KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY! BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) Housework Own home Marvland II.S.A. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME affending) Ada Virginia Zent Joel Bollinger 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16 SOCIAL SECURITY NO. | 17 INFORMANT Address (Yes, no, or unkown) | (If yes give war or dates of service) Mrs. Kennth McKinney, Taneytown, Maryland R.D.1 INTERVAL BETWEEN 18. CAUSE OF DEATH |Enter only one cause per line for (a) (b), and (c) ۾ ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) years. **DUE TO** Conditions, if eny, which gave rise to immediate cause DUE TO (e), stating the underlying cause lest. PART II OTHER SIGNIF, CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e), 19. WAS AUTOPSY CERTIFICATION PERFORMED? 35 NO 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of njury in Pert I or Pert II of item 18.) 206 ACCIDENT WAS UNDERLYING [1] for OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (Stete) 20s. TIME OF INJURY 20e, PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) Month, Day, Year 20d. INJURY OCCURRED fectory, street, office bldg., etc.) Not While While Hour a.m. et work at work 21. I certify that (I) (this hospital) attended the deceased from.... and that death occurred a5 AM, from the causes and on the date stated above. saw the deceased alive on 226 DATE 22 SIGNATUN SIGNED **ATTENDING** STAFF K DIRECTOR PHYS. PHY5. M.D. death. Page 4 22d. ADDRESS 22 - PHYSICIAN NAME DYPE director, 23c. NAME OF CEMETERY OR CREMATORY (State) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23d. LOCATION (City, lown or county) REMOVAL (Specify) 0 H Burial .1967 Reformed Cemeterv Tanevtown. Maryland Sept. 1 3 1967 REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE. ADDRESS VR A15 Son DATE Taneytown, Maryland



di	1	- 1	MARYLAND STATE DE	PAKIMENT OF HEALTH 1 W. PRESTON STREET, BALTIMORE, MARYI	AND 21201
10	. ~1	π\	40000	OF DEATH	12239
	er death. funeral 1 and 2	リ	1. PLACE OF DEATH a. COUNTY Carroll MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institute o. STATE b. COULD Baltimore Follows	
1	uted within 24 hours after impletely filled in by the fur vecarbon papers. Pages 1		b CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) Sykesville, Md. LYr. 3Mos.	CITY OR TOWN (If outside carparate units, write RU Baltimore Maryland	21215
	e executed within 24 hours and completely filled in by remove carbon papers. P n any sperit, within 72 hour	<i>!</i> ^.	d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) Springfield State Hospital	d STREET ADDRESS	e IS RES DENCE ON A FARM? YES NO
}	completely filled ove carbon pape		3. NAME OF First Middle PECEASED (Type or print) Joseph Marion Booker 5 SEX 6 COLOR OR RACE 7 MARRIED 7 NEVER MARRIED 7 8	Last 4. DATE Man OF DEATH SELL. 8 DATE OF BIRTH 9. AGE (n years	
	e execution of company		male Negro WIDOWED DIVORCED DI	6-17-93 [last birthday] 11. BIRTHPLACE (County & State, or lare-on country)	Manths Oays Hours Min
	icate be		during most of working life, even if retired) Laborer 13. FATHER'S NAME	Virginia: 14 MOTHER S MAIDEN NAME	COUNTRY?
	th certification of the Then remays			NFORMANT Addre	ess
	the dea ne atten it permit atian, ar		(Yes, no, or unknown) (If yes give wor or dates of service) NO 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. OEATH WAS CAUSED BY:	inda Bookee 2101 Ku	INTERVAL BETWEEN ONSET AND DEATH
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the haspital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filled with the State Dept. at Health priar ta burial, crematian, ar remaval, and in any exert, within 72 hours after death.		IMMEDIATE CAUSE (a) T + 01 Conditions, if any, which gave (b), stating the underlying cause (c) Lost DUE TO Conditions to immediate cause (a), stating the underlying cause (c)	ic Carbio Vascular Di	SEASE ONSER AND DEALER
	I: The lo or atten te has b use as alth pric	2	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO T	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	19. WAS AUTOPSY PERFORMED? YES NO
	YSICIAN aspital certifica thed far		OR CONTRIBUTING CAUSE OF DEATH	(Enter nature of injury in Port 1 or Part II of item 18)	
	ING PH by the h ter this be detect tate Deg		Hour a.m. p.m. 19 While Not While of work	CE OF INJURY (Hame, form, ary, street, affice bldg., etc.)	(Caunty) (State)
	ATTEND tained to TOR: Af		21. I certify that (1) (this haspital) attended the deceased fram—saw the deceased alive an 7-9 19 6-7, and that	death accurred at 7:55 A.M. fram causes	
	ral or /	,	22c PHYSICIAN'S NAME (Type) Paul G. Ensor M.D.	D. ATTENDING MED. STAFF PHYS DIRECTOR PHYS. C 22d. ADDRESS Baltimore, Md.	22b. DATE SIGNED 9-9-67
	Page 4 may O FUNERAL director, pageshould be file	Ö	230 BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR C	CREMATORY 23d LOCATION (CITY or To	wn) (Caunty) (State)
	VR A15 (4) 20 M 1/66		24. FUNERAL DIRECTOR ADDRESS Ver. J. Kelban 1348 M. Callande St	250. RECD BY REGISTRAR 1967	GISTRAR S SIGNATURE



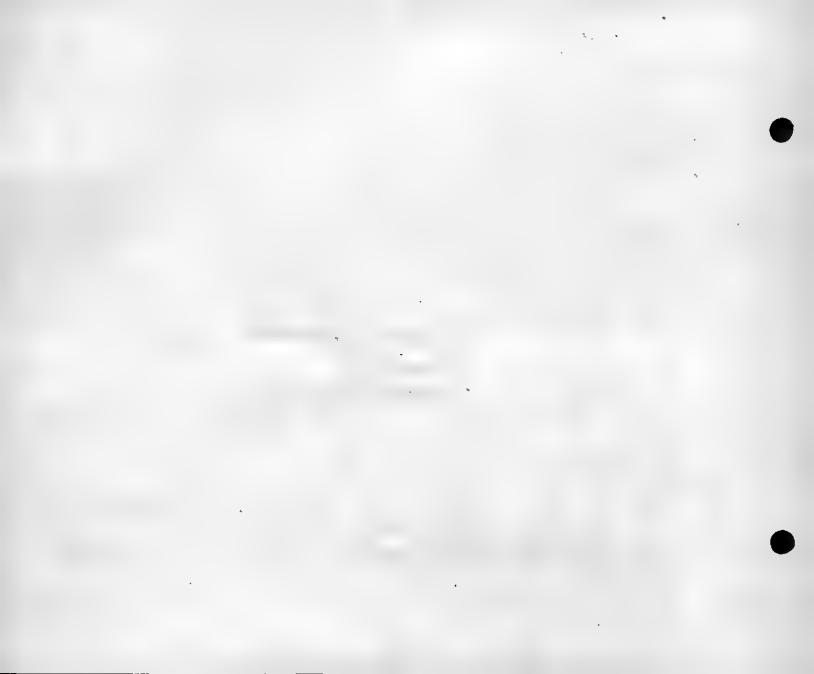
1	Item 10-	© 11√21 19−67 ε	Film 39	93 M LOF VITAL I		ND STATE I S. 301 W. PR				RYLAND 212	01		
FOR STATE		12223				EXAMINE						224	<i>i</i> 0
HEALT DEPT.		E OF DEATH			· · ·			JAL RESIDENCE (Where dece			ence before	odmission)
5 5 8 7 F		DUNTY	arroll			MARYLAN	n []	Marvl	and		OUNTY	1 1	
	Ь (1)	TY OR TOWN (IF	arroll outside corporate I m	nits,	C. LENG	GTH OF STAY IN 15	c CHI)	OR TOWN (If or	uts.de corpo	rote limits, write	RURAL and g	ive neotes	town)
PM3.		Finksbu	give nearest town)					Finlesh	1 NO. CO.				16-1
	d NA	AME OF HOSPITAL	OR NSTITUT ON (IF	not in hospitol,	give stree	nt oddress)	d STR	Finksbu EET ADDRESS	ir.8			T 6	IS RES DENCE
form form		Carroll	County G	'anoral	Uoca	d+o1		Dieleah		Marana Laur	2	١,	ON A FARM? 'ES NO
Pages of the far	3 NAM	IE OF		First	- III - I	Middle		Lost	4 DATE	Marylan M	lonth	Doy	Year
haurs after death If Stem 18. Give Pages 1, Office alang with farm and 2 with the State Dei		ASED or print)	Т	RVIN		E.	ВС	SLEY	OF DEAT		eptemb	er 9.	1967
offer 8. Giv alang with	S SEX		6 COLOR OR RACE	7 MARKIED	X N	EVER MARRIED	8 DATE	OF BIRTH		9. AGE (n years	F UNDE	RIYEAR	IF UNDER 24 HRS
18.0 18.0 18.0 18.0 19.0 19.0 19.0 19.0	Ma	le l	White	WIDOWED		DIVORCED [h 12, 10		last birthday		Doys	Haurs Min
haurs Item 18 Office I and 2 v	10o. US	AL OCCUPATION (Give kind of work don	ie 105 l	(ND OF B	USINESS OR		SIRTHPLACE (Stote		country)		CITIZEN OF	WHAT
24 Hun tin tin tris Cris Cris Cris Cris Cris Cris Cris C	auring in	Parmer "	e, even it retited)	1	NDUSTRY			Marylani	d			COUNTRY ?	
cil 1 cil 1 cil 1 cil 2 cige		HER'S NAME					14. M	OTHER'S MAIDEN	NAME		-		
within 24 haurs and pendium 18. Examiner's Office a file pages Land 2 w haurs after death.	-	Samuel L	Bosley					Mary	y Taw	ney			
bed in Education 19 and	15 WAS	S DECEASED EVER	N u S ARMED FORCES yes give wor or dote:	3? 16	SOC AL SI	ECURITY NO	17 INFORMA	NT		A	ddress		
dia dia limi	10	, or binkinowinj (r	yes give wor or dole:	S OF SELVICE I	20-2	6-57844	Mr. In	vin E. I	Bosle	y Ir. 1	Reiste	rstou	n, Md.
This certificate shauld be executed within 24 haurs after death 1f cate, writing the ward "pending" in pencil in Item 18. Give Pages 1, be farwarded to the Chief Medical Examiner's Office along with farm 1 be used as a burial-transit permit. File pages I and 2 with the Shate Degremand, and in any event within 72 haurs after death.	18	CAUSE OF DEA	IH (Enter only one o	ause per line fo	r (o), (b)	and (c).)						NTE	RVAL BETWEEN
be "pi hief ansi		PAKI I. DEATH	WAS CAUSED BY. JMMEDIATE CAUS	if (a) A S	pira	tion of	mast:	ic con	tents			ONS	ET AND DEATH
old and and and and and and and and and an		10,5		JE TO									
sho e w a th an		dit ons it any, w	couse (o)	(-/	stro	-intest	inal c	bstruc	tion				
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ertificate shauld writing the ward warded ta the Ch sed as a burial-tre fal, and in any ev	last	_	,	(c)									
EXAMINER: This certificate shauld ute the certificate, writing the ward age 4 should be farwarded to the Chyaus fires. Page 3 should be used as a burial-traction, as remayal, and in any everemation, as remayal, and in any everemation.	S PAR		IFICANT CONDITIONS			•						19	WAS AUTOPSY PERFORMED?
ER: This certificate, ould be faces. es. hou d be hou d be	CERTIFICATION 5002		ensive a									YE	S NO
	E ZUO PRI	EXTERNAL CAUS MARY [1] or CONT		20b D	ESCRIBE H	OW INJURY OCCUR	RED (Enter no	iture of injury in	Port or Po	ort I of item 18)			
EXAMINER: cute the certif age 4 should r your fires. Page 3 shour cremation, ar		JSE OF DEATH				7 ppsp 1 ps			501				
MIN the 4 st a fin antique	MEDICAL 30c	Hour a m.	Month, Day, Year	1885.0	INJURY OC	of While		IURY (Home, forn t, office bldg., etc		(City or town) ((lounty)	(State)
XA ute ge yau yau rem		p.m.	15	ot wa	rk 🗀 o	T WORK							
xecu Pa far OR:			that I taak char							_	nquiry 🔲	and	'n my ap n ai
e e ctar ctar ctar buri	(death resulted	d from: Notu	ral causes [XI, A	cc'dent [_],	Suicide [Indetermined	manner		
MEDICAL please executed director. Peroined failure fai	ACI	TUAL	(1) by	-/				CHIEF MEDICAL				2	2. DATE SIGNED
JTY / Iny, plant, plant, plant, plant, plant, plant, plant, plant, prior		NATURE	071	nuc	1		M D	ASSISTANT MEDIC				-	a. DAIL SIONES
Pursul sany burners of the pursul sany burners o	NA	AMINER'S ME (Type)						Address (Stree			0+		0 106
no DEPUTY MEDICAL EXAM necessary, please execute the funera director. Page 4 5 may be retained for your of FUNERAL DIRECTOR: Page Health prior to burial, cremans	23o B.J	RIAL, CREMATION	usacll S	Fisher	7 73C	YAME OF CEMETER	OR CREMATO)RY		OCAT ON (Crty or		ember (County)	9 <u>, 196</u>
5 = = 2	26/	MOVAL (Specify)	Sept.	12,67	PL	easant G	rove			Boring		(200,11)	(3.0.0)
IV V	24 FUI	NERAL DIRECTOR	-			ADDRESS		2So REC	D. BX. REGIS		REGISTRARS	SIGNATUR	£
VR A15ME (5) 17 6M 1/67	7.1	F. Eline	e & Sons	Reiste	ersto	wn, Md.		DATE 5	EL T	T MAI	The same	LUIS	1



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH a. GOUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. GOUNTY von papers. Pages 1. MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 1b c. GITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RUBAL and give nearest town) 3 hester JYEEN mount d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? NO Z executed within etely NAME OF Middle DATE Month DEGEASED OF DEATH and comple remove car 0 (Type or print))en 1967 5. SEX 6. GOLOR OR RAGE OATE OF BIRTH NEVER MARRIED 121 8. AGE (In years ! IF UNDER 1 YEAR IF UNDER 24 HRS remove 7. MARRIED last birthday) | Months | OIVORGED [WIDOWED 10a. USUAL OGGUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 12. GITIZEN OF WHAT COUNTRY? (County & State, or foreign country) death certificate be during most of working life, even if retired) HOUSEKEEDEY and 13. FATHER'S NAME MOTHER'S MAIOEN NAMI remova H. Brodbeck John Annie Boslev 15 WAS DEGEASED EVER IN U.S. ARMEO FORGES? transit permit. 16. SOCIAL SEGURITYNO. 17. INFORMANT Address Ples, m. on unkown) (If yes give war or dates of service) deceased 18. GAUSE OF DEATH [Enter only one cause per line for (a)/(b), and (c). INTERVAL BETWEEN ONSET AND DEATH The law requires that the PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) signed been set burian the burian to 4-16 X DUE TO Conditions, if any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) S CERTIFICATION PART II. OTHER SIGNIFICANT GONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTÓPSY PERFORMED? his certificate tachind for using YES [NO 🖂 208. ACCIDENT WAS UNDERLYING IN OR GONTRIBUTING INCOME OF OFATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ATTENDING PHYSICIAN: 20b. DESCRIBE HOW INJURY OGGURRED, (Enter nature of Injury in Part 1 or Part 1) of Item 18.) 무등 20c. TIME OF INJURY Month, Oay, Year 20d INJURY OCCURRED 20e. PLAGE OF INJURY (Home, farm, 20f. (Gity or town) (Gounty) (State) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work 0 0 21. I certify that (I) (this hospital) attended the deceased from 1962 that (I) (we) last DIRECTOR: age 3 shoul and that death occurred at 1310 M. from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE 22b. OATE SIGNEO page filed MED. DIRECTOR STAFF PHYS. M.O. FUNERAL O HOSPITAL direntor, pe PHYSICIAN'S 22d. ADDRESS NAME (Type) BURIAL CREMATION 1 235. DATE THEREOF 23c. NAME OF GEMETERY OR CREMATORY 23d. LOGATION (Gity, town or county) (State) 18. Sept. Greenmount Cemetery Greenmount. FUNERAL DIRECTOR AOORESS 25a. REG'O BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Tipton - Eline Funeral Home Hampstead, Md. VR A15 (4) 20M 1/65



1		Division of STATISTICAL RE	MARYLAND STATE DEF SEARCH AND RECORDS, 301			1201
(A)		12231	CERTIFICATE	OF DEATH		12242
PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death he hospital or attending physicion. his certificate has been signed by the ottending physicion and completely filled in by the funeral-stacked for use as the buriol-transit permit. Then please remove carbon papers. Pages I and Dept. of Health prior to buriol, cremation, or removal, and in any event, within 72 hours ofter death.		ACCOUNTY CAPPOLL	MARYLAND	2. USUAL RESIDENCE (Where de a. STATE	ceased lived, if institution Resid b. COUNTY	ence before admission) ACCO
by the S. Poges	U	OCITY OR TOWN (If autiside corporate Limits, write BURAL and give innotest tawn) WESTMINSTER RAME OF MOSPITAL OR INSTITUTION (If not in hospit	c LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside con UESTMI)	porate limits, write RURAL and g	e, IS RESIDENCE
filled in panes.		CARROLL County	Hospital	Route á	2	ON A FARM? YES NO
within tribon it, with		VAME OF DECEASED Type of print) E/Sie. First	Annmarie (LARK OF	TE Month Septia	Doy Year 23. 1967
executed with and completely remove carbon any event, with	5	EX 6 COLOR OR RACE 7 MARR EMALE White WIDOW	/ED DIVORCED	9-23-67	9 AGE (In years of UNDE last birthday) Manths yrs	R 1 YEAR IF UNDER 24 HRS
te be exion and indin an		USUAL OCCEPATION (Give kind of work done ng mast of warking ite even if retired)	KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State,	or fareign country) 12	CITIZEN OF WHAT
certificote be g physicion c fhen please moval, and ir		Robert J. Cli	PRK	14. MOTHER'S MAIDEN NAME BEVERL	J. Lea	lford
equires that the death ce physicion. signed by the ottending buriol-transit permit the burial, cremation, or remo		was deceased ever IN U.S. ARMED FORCES? , no. or unknown) (If yes give wor ar dates of service)	- MR	Robert C	PARK-West	minster, My
that the ny the consit premation		18 CAUSE OF DEATH (Enter only one couse per line PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o)	torto (b) and (c))	Quatron	fyndione	ONSET AND DEATH
puires 1 ohysicio igned l uriol-tr uriol, ci		Canditians, if any, which gave (b) (b)	Provalurely		0	
day reconding page 100 page 10		stating the underlying cause last (c)	Materna	l Lycer	/	
AN: The law rale of or ottending icate has been for use as the Health prior to	ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION	NG TO DEATH BUT NOT RELATED TO TH	HE TERMINAL DISEATE CONDITION	GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES NO
OR ATTENDING PHYSICIAN: The law requires that the death certificate be exected by the haspital or attending physician. DIRECTOR: After this certificate has been signed by the ottending physician and cape 3 should be detached for use as the buriol-transit permit. Then please removed with the State Dept. of Health prior to buriol, cremation, or removal, and in any	A CERTIFICATION	OR CONTRIBUTING □ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	. DESCRIBE HOW INJURY OCCURRED (E		Part II of item 18.)	
by the hospir frer this certi be detached State Dept. or	MEDICAL	Haur o.m.	d. INJURY OCCURRED 20e PLACI /hile Not While foctor work of work	E OF INJURY (Hame, form, 20 ry, street, office bldg , etc.)	Of (City or tawn) (C	County) (State)
=		21. I certify that (this hospital) of saw the deceased alive on	tended the deceased fram	9-23, 1967 death accurred at 5:22	, ta	the date stated above
OR ATTENION OF STENION		22a SIGNATURE	Keen MD	ATTENDING MED. PHYS DIRECTO	STAFF 22b	DATE SIGNED
moy be RAL DI Company be possible filed		22c. PHYSICIANS KARL M.	Green	22d. ADDRESS Westmir	ster. Md	
TO HOSPITAL OR ATTEN Poge 4 may be retoined TO FUNERAL DIRECTOR: director, poge 3 should Should be filed with the		BURIAL (REMATION, 23b DATE THEREOF REMOVAL (Specify)	230 NAME OF CEMETERY OR CO SPRINGFIE	REMATORY 23d	LOCATION (City or Town) Sukesville.	(County) (Stote)
VR A15 (4)	24	FUNERAL DIRECTOR KNIGHT	ADDRESS MA	250. REC DIBY REG DATSEP 2		SIGNATURE Con Surger



X I		12232 Division of STATISTICAL RESEARCH AND RECORDS 3	OJ W. PRESTON STREET, BALTIMORE, MARYLAND 27	1201
FOR STATE		MEDICAL EXAMINER'S	CERTIFICATE OF DEATH	2843
HEALTH DEPT.	H	PLACE OF DEATH	2 USUAL RESIDENCE (Where deceased lived, if institution Reside	ence before odmission)
10 6 to 1-		o COUNTY	o STATE b COUNTY	1
		b CITY DR TOWN (If outside corporate limits, C LEAGTH DE STAY IN 1b	Maryland Montgon c (ITY DR IDWN (f outside corporate mits, write RURAL and gr	ne negrest town)
delay management riment er dea		write RURAL and give nearest town) Rural - Sykesville 6 mos. 2 day		10.4
Pp 2,2		d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)	d STREET ADDRESS	e 15 RESIDENCE
after death If any delay 8 Give Pages 1, 2, apr 3 along with farm PM with the State Department within 72 haurs ofter dea		Springfield State Hospital		ON A FARM?
after death 8 Give Page along with f with the Stat	3	NAME OF First Middle S	Lost 4 DATE Month	Doy Year
after death 8 Give Paga along with with the Sta		DECEASED (Type or print) JAMES (1801)	COCKRILL OF September :	191967
on of the with with	5	SEX 6 CDLOR OR RACE 7 MARRIED NEVER MARR ED	8 DATE DE BIRM 2/1888 9 AGE (In years FUNDE	R I YEAR IF UNDER 24 HRS
urs ce		Male White WIDOWED XX Sec. DIVORCED	5-/	
24 hours in Item 1: is Office or and 2: iny event	10c dur	USUA, DCC.PAT DN (Give kind of workgoogs 10b KIND DF BUSINESS OR	1) BIRTHPLACE (State or foreign country) 12 C	CTIZEN OF WHAT COUNTRY? USA
hin 24 neel in li	12	no most of work not be even frebred to all the Krodd Me Yddy repairman My SHRD FATHER'S NAME A		USA
if the first state of the state	13		14. MOTHER'S MAIDEN NAME	,
d within in pencil in Examiner File Sage	- 5	James / Cockrill WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SDCIAL SECURITY NO 17	Fannie (last name unknown)
girl roal,	(Y)	es, no, or unknown) lift yes give wor or dotes of service)	ecords, Springfield State Hospi	5 h = 3
be executed within pencil her medical Examine this forms to the page ar remayal, and in a		18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)	scords, bpringileid boate noso	I CAL
should be e ne ward "per a the Chief I burial-transit matian, ar re		PART I DEATH WAS CAUSED BY	to rheumatic heart	ONSET AND DEATH
The state of the s		4/1 X DUE TO	, IV TAGENICO DE TAGEN	
ther the urra		Conditions, if ony, which gove) (b) Mitral stenosis		Vegre
te s the d ta d ta b		rise to immediate couse (o). stating the underlying couse		
ertif cate should writing the ward rwarded ta the Ch sed as a burial-tra		lost (c) Rronchopneumonia		days
certif cate should , worting the ward arwarded to the Cl used as a burial-tra burial, cremation,	S	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO		9 WAS AUTOPSY PERFORMED?
This cate, be fa	CA	Chronic brain syndrome with senile brai		tionyes X NO
두 우.호	L CERT F CATION	200 EXTERNAL CAUSE WAS PRIMARY □ or CONTRIBUTING □ CAUSE OF DEATH	(Enter noture of injury in Port I or Port I of item 18)	
EXAMINER: ute the cert age 4 should your files Page 3 shau ed agent, pr	MED.CAL		LACE OF INJURY (Home form, octory, street, office bldg , etc.)	County) (State)
MEETAL EXA please execute director. Page estamed far you DIRECTOR: Pag		21 I certify that I took charge of the remains described above, h	held on Autopsy 💢 , Inspection 🗍 , Inquiry 🗍 ,	ond in my opinion
r exercing the second s			sicide, Homicide, Undetermined monner	
MEDICAL please e I director retained DIRECT its design		ACTUAL /129/2 / Section	CHIEF MEDICAL EXAMINER	99 DATE CLOHED
Y M ple oil di oil di reto		SIGNATURE VICENCY Deren	M.D ASSISTANT MEDICAL EXAMINER	22. DATE SIGNED
TO DEPUTY MEDICAL EXAM necessary, please execute the funeral director. Page 4 5 may be retained for your TO FUNERAL DIRECTOR: Page Health ar its designated age		EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.	DEPUTY MEDICAL EXAMINER (A) OCCUPTY)	, , , ,
DE Peces me fremmer FUJA	230	BUR AL CREMATION 23h DAZE THEREIDE 23c NAME OF CEMETERY OF		(County) %Stote)
5 g = 4 2 E =		REMOVAL (Spec fy) 772 67 M273	12/1 (477) 4 19-77 5707	11/10
VR A15ME (5)	21	FUNERAL DIRECTOR ADDRESS W	(ash- 250 REC D BY REG STRAR 250 REG STRARS	SIGNATURE 1 7/22
AK WIDWE IDI		17/ 1/1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/ 1/	~ - ICED 7 5 1957 745 7	19 11 100



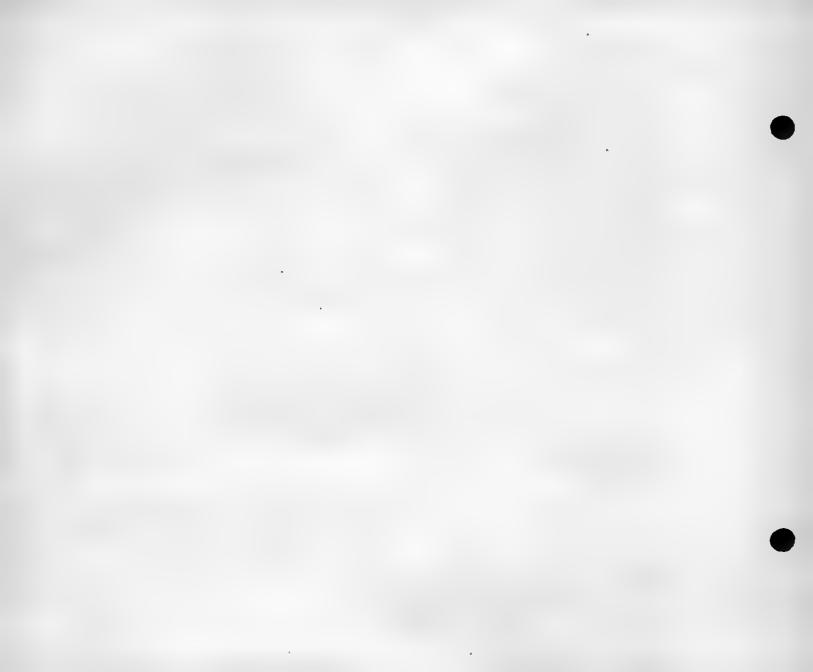
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission a COUNTY o. STATE b CO., NTY Carroll Marvland MARYLAND Frederick b CTY OR TOWN (if outside corporate mits, c CITY OR TOWN (If autside corparate limits, write RURA, and give nearest tawn) c LENGTH OF STAY IN 16 write RURAL and give nearest town)
Westminster ofter Rural -- Ermitsburg. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS B IS RESIDENCE ON A FARM? hours ote Westminster Carroll YES NO JE hours after death. Office along, with 3 NAME OF Middle 4 DATE L Month Doy Year DECEASED G-ve WITH (Type or print) DEATH S SEX 6, COLOR OR RACE 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED B DATE OF BRITH AGE (In years last birthday) Doys Haurs Malle White DIVORCED May 29. 1928 WIDOWED gud 100 JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT INDUSTRY COUNTRY? VID Taylorsville, Md. ⊑ Painter Examiner 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME ⊆ With Arthur Crawford Ethel Duvall pup WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address R. D# 2 be executed (Yes, no, or unknown) (If yes give war or dates of Yes 11/20/50, 11 Chief Medical permit. remayal, 20752*213-24-9688 Mrs. William L. Crawford, En itsburg, Md. IB. CAUSE OF DEATH (Enter only one cause per Integral (a), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY-INSET AND 9 (MMEDIATE CAUSE (o) +201 This certificate shauld cremation, DUE TO Conditions, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause last 8 burial, nsed PART II OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? NO DO the certificate. YES designated agent, prior to 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW MURY OCCURRED (Enter nature of injury in Part or Part N of Item 18) PRIMARY I or CONTRIBUTING I CAUSE OF DEATH MEDICAL 20c. TiME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or fown) (Caunty) (State) Hour o.m. factory, street, office bldg , etc) Not While at work at wark 21. I certify that I took charge of the remains described above, held an Autopsy Inspection . and in my opinion Inquiry ..., death resulted from: Notural causes X Accident Suicide [Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE 4 the funeral FUNERAL DEPUTY MEDICAL EXAMINER **EXAMINER'S** 34 Toler is the form of south Westminster, ro FUNE Health NAME (Type) W. Glenn Speicher BUR AL CREMATION 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY *fith or Town) (County) (State) REMOVAL (Specify)
Burial Keysville Carroll Co. Md. Kevsville Cemeterv 24 FUNERAL DIRECTOR 2Sq REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE VR ATSME (5 DATESEP 6M 1/66 Emmitsburg. Md.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12234 12245 Item #2d Film CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours ofter death. funerol PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE **b.** COUNTY Carroll Maryland Carroll MARYLAND afte b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) popers. Page hin 72 hours c write RURAL and give neorest town) Sykesville 2 mons and NAME OF MOSPITAL OR INSTITUTION (If not in hospital, give street address) Sykesville 2 mons 6 days .⊆ d. STREET ADDRESS e IS RESIDENCE ON A FARM? within 72 unknown Springfield State Hospital YES NO X NAME OF Middle First Lost 4. DATE Doy Year ond completely DECEASED OF event, MARY ELIZABETH DARDAS September 10 19 67 (Type or pont) DEATH 9. AGE (in years 6. COLOR OR RACE 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED M birthdoy) Months Doys Hours â White WIDOWED 8-14-89 DIVORCED Female 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Maryland None 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removal, Jacob Dardas Louise Catherine IS WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dotes of service) 16. SOCIAL SECURITY NO 17. INFORMANT Records. Springfield State Hospital Unknown INTERVAL BETWEEN i8. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the burial-tronsit g PART I DEATH WAS CAUSED BY ONSET AND DEATH Terminal uremia and bronchopneumonia IMMEDIATE CAUSE (o) _ DUE TO Conditions, if ony, which gove Marked peripheral arteriosclerosis with gangrene rise to immediate cause (a). DUE TO for use os the l Heolth prior to b stoting the underlying couse hos been lost. (c) Generalized arteriosclerosis PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA, DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS AUTOPSY PERFORMED? NO X ATTENDING PHYSICIAN: 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e, PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (City or fown) (County) (Stote) factory, street, office bldg, etc.) ot work After , 19 67 , to September 1 09 67, that (A) (we) las 21. I certify that (A (this haspital) attended the deceased fram. July h be retained TO FUNERAL DIRECTOR: saw the deceased alive an and that death accurred at 2:10AM, from causes and on the date stated above 226 DATE SIGNED 220 SIGNATURE ATTENDING M.D PHYS PHYS director, page should be filed 22d ADDRESS Springfield State Hospital SHYSICIAN NAME (Type) Agustin del Sykesville, Maryland 21781 23o BURIA, CREMATION (County) (Stote) REMOVAL (Specify) 24. FUNERAL DIRECTOR 250. REC'D BY REGISTRAR VR A15 (4)



		Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	2010
FOR STATE		12235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	2246
HEALTH DERT	ī	PLACE OF DEATH o. COUNTY Carroll Maryland 2 USUAL RESIDENCE (Where deceosed ved, if institution: Residence to County Carroll Maryland Carroll	,
Park Far	H	Carroll Maryland Maryland Carr City OR TOWN (f outside corporate imits C EENGTH OF STAY N 1b C CITY OR TOWN (f outside corporate mits, write RURAL and give ne	
0 2 40 -		write RURA, and give nearest town)	ignest rown)
aff	Н	Taneytown d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS	e IS RESIDENCE
Give Pages 1, and with farm the State De, thin 72 haurs		55 George Street 55 George Street	ON A FARM? YES NO X
death e Page with f	3	NAME OF First Middle Lost 4 DATE Month	Doy Year
ofter death S Give Page slong with the State with 12 A	L	OFCEASED (Type of pnot) MILDRED (ORA DERN DEATH 9	21 1967
20 00 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	5	SEX 6 COLOR OR RACE 7, MARR ED NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years lost birthday) Months Downth 10 10 10 10 10 10 10 1	AR IF UNDER 24 HRS
haurs Item 1 Office I and 2 event		10 USUA, OCCUPATION (Give kind of work done IND KIND OF 8USINESS OR IN BIRTHPLACE (State or foreign country) 12 CITIZE (COUNT)	N OF WHAT
5 c s	L	None None Maryland U.S.	, A.
min pag m	13	3 FATHER'S NAME Lloyd C. Dern 14 MOTHER'S MAIDEN NAME Florence Lowman	
-0 -	15	S WAS DEFEASED EVEN IN ILS ARMED EDDES? 14 SOCIAL SCILIPITY NO 17 INFORMANT Address	
execute nding' Medical permit maval,	L	(es, oo. orunknown) (If yes give wor or dotes of service) None Lloyd C. Dern 55 George St., Tar	ney bown ,Md.
per re		PART DEATH (Enter on y one couse per line for (a) (b), and (c) y) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) JULY IMMEDIATE CAUSE (b)	NTERVAL BETWEEN
auld ward he C ial-tr		Conditions, if any, which gave)	/-/
ta t ta t bur		rise to immediate couse (a),	_
ing the ded in a sa a a li cre		stating the underlying couse (c)	
is certificate shauld e, writing the ward farwarded ta the Cl e used as a burial-tra a burial, crematian,	MOIT	PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19 WAS AUTOPSY PERFORMED? YES NO
Thi ficat l be ld be	CERTIFICATION		The state of the s
MIN the the 4 sh 4 sh 2 sh 2 sh 3 sent	MEDICAL	20c TIME OF INJURY Month, Doy, Year Hour a m p m 19 20d INJURY OCCURRED 20e PLACE OF INJURY (Name, form, p m 19 at work at w	Y) (Stote)
AL EXA execute or Page of for you TOR: Pag gnated o			and in my apinion
LECAL EX sase executions and a control of the contr		death resulted fram Natural causes X, Accident , Suicide , Homicide , Undetermined manner	
MECTO director retained DIRECTO		ACTUAL CONTRACTOR CHIEF MEDICAL EXAMINER	22. DATE SIGNED
Y M		SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER L	214 W/ 647
o DEPUTY ME. At 1 in necessary, please executive funeral director. Parange of Euneral Director of Euneral Directors: Health or its designate		EXAMINER'S NAME (Type) 77. Glenn Spetcher Address Strength Address Strengt	11/1/
The t	23	BO BURIAL, CREMATION, 236 DATE THEREOF 230 NAME OF CEMETERY OR CREMATORY 23d LOCATION MAY OF TOWN) (CO	unty) //L(ote)
- E DR	_		cuses
VR AISME (S)	1	4 FUNERAL DIRECTOR (John 14. The address sign	to Judge
6M 1/66'\]	2	.O. Fuss & Son John H. Skiles Taneytown, Md. DATE SEP 2 2 1091	0



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission PLACE OF DEATH **b.** COUNTY o. COUNTY ARROLL MARYLAND 2 hours affer c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest fawn) b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) the law requires that the death certificate be executed within 24 hours Sykesville h mo 2 da Baltimore City à e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS ⊆ 33 York Court, Balto. 21218 and campletely filled NO Z Springfield State Hospital 3. NAME OF Middle 4. DATE Month First Day Year DECEASED WALTER JMN FINNET 67 19 Type or print) DEATH B. DATE OF BIRTH IF JNDER I YEAR IF UNDER 24 HRS 9 AGE (n years 6. COLOR OR RACE 7 MARRIED **NEVER MARRIED** the ottending physician and camp sit permit. Then please remove cremation, ar removal, and in any ev b rthday) Hours 08/20/67 White WIDOWED 100 Male DIVORCED 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 10g JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of warking life, even if retired) INDUSTRY Electrical Engineer Crown Cork &Seal Maryland, Churchville 13. FATHER'S NAME J 14 MOTHER'S MAIDEN NAME George/Finney Louisa Lyons Webster IS WAS DECEASED EVER IN U.S. ARMED FORCE S? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, na, or unknown) (If yes give wor or dates at service) Springfield Hospital Records 220-07-3057 INTERVAL BETWEEN B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burnal-transit PART I DEATH WAS CAUSED BY. ONSET AND DEATH IMMEDIATE CAUSE (a) signed by DUE TO burial Canditions, if any, which gave rise ta immediate cause (a), DUE TO stoting the underlying couse Page 4 may be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been as the priar tal lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPS!
PERFORMED? be detached for use State Dept. af Health p CBS assoc. with senile brain disease with psychotic reaction NO X 205, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING ☐ OR CONTR BUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (State) 20e. PLACE OF INJURY (Hame, farm, (City or lawn) (County) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year foctory, street, affice bldg., etc.) at work ta 9/15/67, 19__, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram 5/13/66 . 19 saw the deceased glive an 9/15/67 19 , and that death accurred at 2:15 PM, fram causes and an the date stated above. 22b DATE SIGNED 220 SIGNATURE MED DIRECTOR STAFF PHYS. 9/15/67 0.66 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) COM Springfield State Hospital director, g 23d LOCATION (City or Town) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) 230 BURIAL, CREMATION. REMOVAL (Specify) Churchville Presb. Ch. | Churchville
ADDRESS | 250, REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR & Sons Co Road



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter deoth

Page 4 may be retained by the hospitol or attending physicion.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

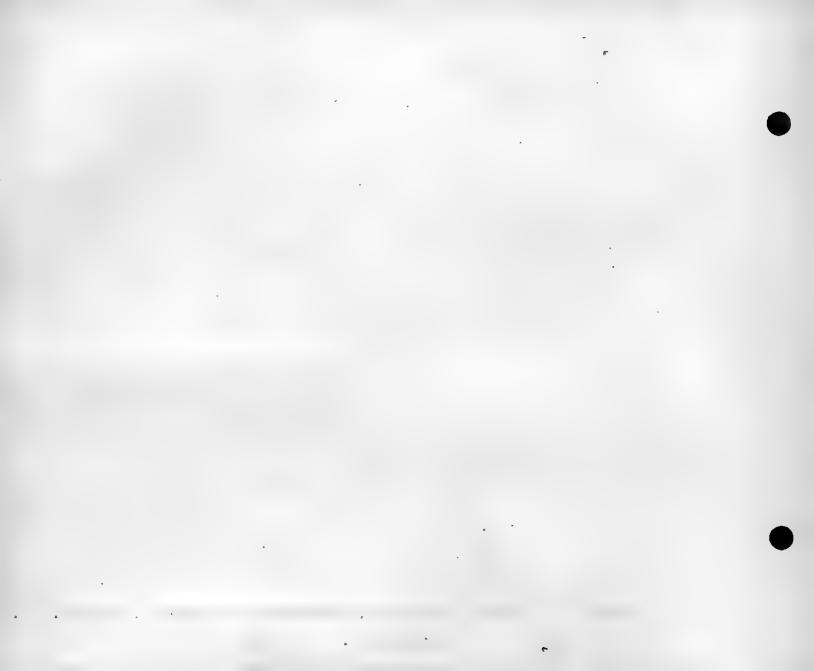
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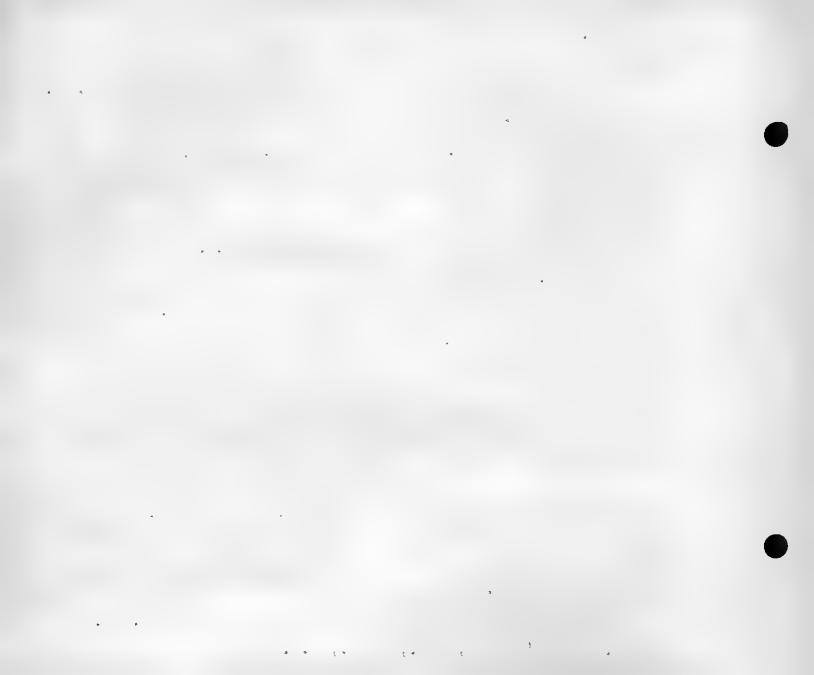
- Sec 6	1) 4	CEKTIFIC	AIL OF D	CAIN		1 %	40
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a COUNTY	Carroll (or	unty MARYLA	ND 0 STATI	Maruland	P COFI	NTY Bal	timore
b CITY OR TOW	(If outside corporate limits	s, c LENGTH OF STAY IN	lb c CITY OR	TOWN (If outside corp	arate limits, write RU	IRAL and give ne	earest town)
Syre	and give pearest town)			Ruxton.			13.0
and A a		ot in hospitol, give street oddress)	d. STREET				e IS RESIDENCE ON A FARM?
Golde	n Age Nursi	ng, Home		aple Avenu	e		YES NO
B. NAME OF DECEASED		rst Middle	las	4. DAT		4	Day Year
(Type or print)	John		Fishpaw	DEA	-		9 1967
SEX	6 COLOR OR RACE	7 MARRIED NEVER MARRIED	8. DATE OF !		9. AGE (n yeors last birthday)	Months Do	AR IFUNDER 24 HRS Dys Haurs Min.
Male	white	WIDOWED DIVORCED	Nov. 1		115		
luring most of work	ON (Give kind of work done ng life, even it retired)	106 KIND OF BUSINESS OR Baltimore (our	11. BIRTHE	LACE (County & State, or	foreign country)	12 CH ZE	N OF WHAT IRY?
netined 3. FATHER S NAME	clerk	Baltimore (our		anyland		USA	
-	, , , ,		14. MUTHE	R'S MAIDEN NAME	0		
	Et Fishparu VER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO.	17. INFORMANT	Martha Le	Q.L. Addr	A.C.	
(Yes, na, ar unknaw) (If yes give war or dates o			u records	Addit	B 22	
	DEATH (Sates only one sou	15e per line for (a), (b), and (c).)	rance	<u>u recorus</u>			INTERVAL BETWEEN
	ATAN AND A BALLET MAINTEN, MAIL	States in selecc	to ble	unt 1	Discos	0 1	ONSET AND DEATH
4200	IMMEDIATE CAUSE	TO a					1 Mecro
	ny, which gove)	10) Generalized	arteri	o seler	oais		2
	ate cause (a), DUE	1					
last.)	(c)					
PART IL OTHER	SIGNIFICANT CONDITIONS C	ONTRIBUTING TO DEATH BUT NOT RELATE	ED TO THE TERMINA	DISEASE CONDITION G	IVEN IN PART 1(0)		19. WAS AUTOPSY PERFORMED?
200 ACCIDENTS OR CONTRIBUTION	Circho	is of liver					YES NO C
200 ACCIDENT	/AS UNDERLYING ☐ IG ☐ CAUSE OF DEATH	206 DESCRIBE HOW INJURY OCCU	IRRED. (Enter nature	of injury in Part 1 or 1	Part II of item 1B)		
(IF EITHER, NOT	FY MEDICAL EXAMINER)						
20c TIME OF Hour		20d INJURY OCCURRED 20 While Mot While M	De PLACE OF INJURY factory, street, af		(City or town)	(County	(State)
	p.m. 19	gt work L at work L	- 0/4		9/10	- 16	
		petal) attended the deceased fro	om // 3	curred of 4.30 A	ta77_	1967	, that (I) (we) lo
saw the 22a, SIGNATU	deceased alive an	19 6 7, and	a mar aeam ac	curred of 7	Lin, Itam causes	22b. DATE	
220.3010	1 and 10	e los	M.D. PHYS.	NG MED DIRECTOR	STAFF PHYS.	7 9	21/65
22c PHYSICIA		the into	22d. A		D Mis. C		0-11-0-1
NAME (Ty	DE) HARRY	DEIBELI	1-0				
23a BURIAL, CREMA		EREOF 23c. NAME OF CEMETE	RY OR CREMATORY	23d	LOCATION (City or To	rwn) (Ca	unty) (State)
Bureal Spe	^(fy) 9=22-6		Hill Cen	etery 7	owson	Balti	· ML.
24 FUNERAL DIRE		ADDRÉSS A1 Z	/	250 REC'D BY REGI	STRAR 1967 RI	EGISTRAR S SIGN	ATURE Judge
John F	urns Sons	Towson, Md.		DATE OLF			9



1	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1	I. MARYLAND
The sale	12238 CERTIFICATE OF DEATH	2249
までリー	1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If Institution a. STATE b. COUNTY	11 0
filled in by the papers. Pages in 72 hours aft	b. CITY OR TOWN (if outside corporate limits, write RU write RURAL and give nearest town) MARYLAND C. LENGTH OF STAY IN 1b C. CITY OR TOWN (if outside corporate limits, write RU write RURAL and give nearest town)	
72 hours	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
any event within 72	Intercent Menor Home due 1282 martist. 3. NAME DE DECEASED J. First Middle Last 4. DATE Month OF OF	YES NO C
	(Type or print) 7 and Bulle + Ita DEATH 9 5. SEX 6. COLOR OR RACE 7. MARRIED MARRIED THE 8. DATE OF RIGHTH 19. AGE (In years) IF UN	17 1967 DER 1 YEAR IF UNDER 24 HR
	Jernole WIDOWED DIVORCED Let 10, 1880 Ft. yrs. 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11L BIRTHPLACE (County & State, or foreign country) 12	2. CITIZEN OF WHAT
	Manager of working life, even if retired) INDUSTRY Manager of Jurisly Stree 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	COUNTRY?
ellova ellova	Jacob Leslie 7 itz Hennetta Zullinger	0
5 6	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, by, or unknown) (Ityes give war or dates of service) 219-54-1014 Ray C 7 st (righter). Charm	ain, Pa.
or to burial, cremation, or removal,	18. CAUSE OF OEATH (Enter only one cause per line for say, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to Immediate (b) Cause of Carallel Canada Caralle	INTERVAL BETWEEN ONSET AND DEATH
NOTE	Cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	PERFORMED?
TO CEPT. OF HEALTH PLOT OF	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item OR CONTRIBUTING CAUSE OF OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	YES NO
10010	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm.) 4 Hour a.m. While Not While at work at work at work	(County) (State)
		967, that (I) (we) las
Should be nied with	22a. SIGNATURE M.D. ATTENDING MED. DIRECTOR STAFF PHYS. DIRECTOR PHYS. 22b	. DATE SIGNED
	226. PHYSICIAN'S NAME PLYOF) NAME PLYOF PLATER DESCRIPTION OF THE PLA	pryland
- 1-	Burial (REMATION, 23b. Date thereof 23c. Name of CEMETERY OR CREMATORY 23d. LOCATION (City, town of Burial 9/19/67 Methodist, Fountaindale Fairfield #1, A	dams Co. Pa.
	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGIST	RAR'S SIGNATURE
\$-::		



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12250 12239 CERTIFICATE OF DEATH O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission o. COUNTY o. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, Mont. Co. in by the fers. Pages C LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town write RURAL and give nearest town)
Sykesville, 11d 21 months Chevy Chase e IS RESIDENCE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS ON A FARM? filled i Springfield State Hosp. Sykesville Md 34 W. Kirke S First completely DECEASED DEATH September (Type or pnnt) John atrick Pitzgerald 9 AGE (n years lost birthdoy) S. SEX 6. COLOR OR RACE B. DATE OF BIRTH TE UNDER 1 YEAR 7 MARRIED **NEVER MARRIED** Months Dovs male White WIDOWED DIVORCED March 11 ha 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) None Washington D.C.
14. MOTHER'S MAIDEN NAME U.S.A 13. FATHER'S NAME ar removal, Clara Felton Bernard M. Fitzgerald 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 17. INFORMANT signed by the atter burial-transit permit burial, cremation, a Springfield St te Hosp, Sykesville Md one 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE (AUSE (a) Sub-acute bacterial endocarditis Weeks DUE TO Conditions, if ony, which gove nse to immediate couse (a), DUE TO stating the underlying couse has been (c) Congenital heart disease-aortic stenosis vears 19. WAS AUTOPSY PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) PERFORMED? Pneumonitis YES [NO X TO FUNERAL DIRECTOR: After this certificate 200, ACCIDENT WAS JNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of 'njury in Part I ar Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e, PLACE OF INJURY (Home, form, 20c. TIME OF N.JRY Month, Doy, Year 20d INJURY OCCURRED (City or fown) (County) Hour o m. foctory, street, office bldg., etc.) 21. I certify that (I) (this haspital) attended the deceased fra July 11, 19 67, to Sept. 3, 19 67 that (I) (we) los saw the deceased alive an Sept. 3, 19 67, and that death accurred at 2-1,0 M, fram causes and an the date stated above director, page 3 shauld shauld be filed with the 22o. SIGNATURE / 22b. DATE SIGNED **ATTENDING** MED DIRECTOR M.D. PHY5 Springfield State Hospital 22c PHYSICIAN'S NAME (Type Octavio 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City of Town) 230. BUR AL, CREMATION 23b DATE THEREOF 9/6/67 Wheaton, Gate of Heaven 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR 250 REC'D BY REGISTRAR VR A15 (4) 25M 1/67 1987 Jos. Gawler's Sons, Inc., Wash., D.C. DATE SEP

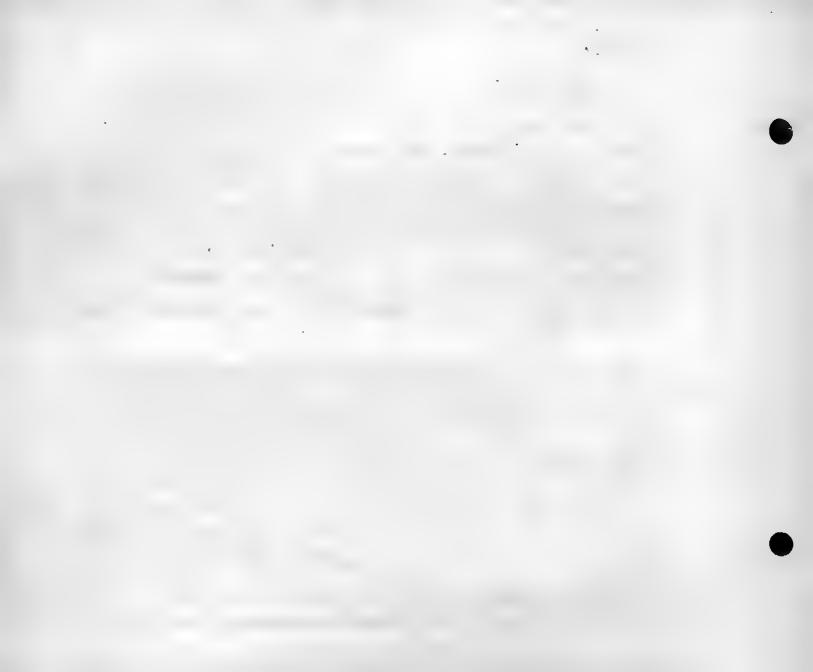


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 2120 12240 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fived, if institution Residence before admission) o COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside comprote limits, write RURA, and give nearest town) law requires that the death certificate be executed within 24 hours of papers. Pag. hin 72 hours a write RURA, and give nearest town signed by the attending physician and camplatety-दापिटों in b.k. burial-transit permit. Then please remove,Carbon papers. P d NAME OF HOSPITAL OR INSTITUTION (if not a hospital, give street oddress) d. STREET ADDRESS ON A FARM YES NO 4 NAME OF Middle DATE Month DECEASED OF (Type or pnn!) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED last birthdov) Hours Tale DIVORCED WIDOWED 105 KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10b USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) during most of working ite, even if retired) COUNTRY? A. INDUSTRY 13. FATHER'S NAME MIQMIN INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service) INTERVAL BETWEEN 1B CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) PART 1. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO months Conditions, if any, which gave rise to immediate couse (a), DUE TO stoting the underlying couse Page 4 may be retained by the haspital or attending O FUNERAL DIRECTOR: After this certificate has been ê Ļ WAS AUTOPS PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? NO 卓 205 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20d ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year Hour o.m. factory, street, office bldg., etc.) Not While of work 21. I certify that (I) (this hospital) attended the deceased fram_ 1967, and that death occurred at 250 M, from couses and on the date stated above. saw the deceased alive on 220 SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS 22d ADDRESS 22c. PHYSICIAN S NAME (Type) director, should 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o. BURIAL, CREMATION, 1967 National Capital Hebrew Hillside, Maryland. 4. Stein Hebrew Memorial 232 Carroll Washington, 250 REC'D BY REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66





1	1	MARYLAND STATE DEPARTMENT Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTO		21201
		12242 CERTIFICATE OF DE	ATH	12253
er death		PLACE OF DEATH O COUNTY ARROLL CO - MARYLAND 2 USUAL RE O STATE	SIDENCE (Where deceased lived, if institution Re b. COUNTY	ARROLL
24 hours aftered in by the sapers Pages 172 hours after	1	b. CITY OR TOWN (If autside corporate l.mits, c LENGTH OF STAY IN 1b c CITY OR TO	TWN (If autside corparate limits, write RURAL and TIMINS TEQ RT#	d give negrest tawn)
24 ed 72			REESE	ON A FARM? YES NO
d within etety financh or with		NAME OF DECEASED (Type or print) EVA SUE HAHN Lost	4. DATE Month OF DEATH	Day Year 14 1967
s executed withing and campletely fremave carbon agy event, with			5 1894 73 yrs Mon	
ficate be exysteran and please remail, and in as	dur	ring most of working life, even if retired) INDUSTRY CHAT		COUNTRY?
h certifii ing phys Then p emaval,		CHARLES BARKSDALE PIL	VRIE ROGERS	
attendin permit ion, ar re	(Ye	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 214-01-0676 DVDLEY 18. SOCIAL SECURITY NO. 19. DVDLEY	E. GREENHOLTZ 38 HOL	K RD.
the the mating		18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO	REST	INTERVAL BETWEEN ONSET AND DEATH
It The Taw requires that the ar attending physician. It has been signed by the use as the burial-transit saith priar to burial, cremating		Conditions, if any, which gove inse to immediate cause (o), stating the underlying cause DUE TO	HEBRT PISIERSE	YEARS
rificate has been d far use as the af Health priar ta	ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D	ISEASE CONDITION GIVEN IN PART 1(0)	19 WAS AUTOPSY PERFORMED? YES NO
	L CERTIFICATION	20o. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
O HOSPITAL OR ATTENDING PHYSICIAN Page 4 may be retained by the hospital O FUNERAL DIRECTOR: After this certifica directar, page 3 should be detached fails shauld be filed with the State Dept af He	MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 20d INJURY OCCURRED While at wark at	Hame, form, bldg , etc.) 20f (City or town)	(Caunty) (State)
R ATTENDING PHYSICIAN: retained by the hospital ar RETOR. After this certificate 3 should be detached feel with the State Dept at Heal			urred at 7 5 M, from couses and	
OR AT be reta VIRECTO Be 3 sha		Livent of proces of M.D. ATTENDING	DIRECTOR PHYS.	2b DATE SIGNED
FITAL may ERAL I		222 PHYSICIAN S NAME (Type) 22d. ADI		
TO HOSPITAL OR Page 4 may be a TO FUNERAL DIRECTOR, page 3 should be filled by	230			
VR A15 (4)	24	4. FUNERAL DIRECTOR ADDRESS		ARS SIGNATURE



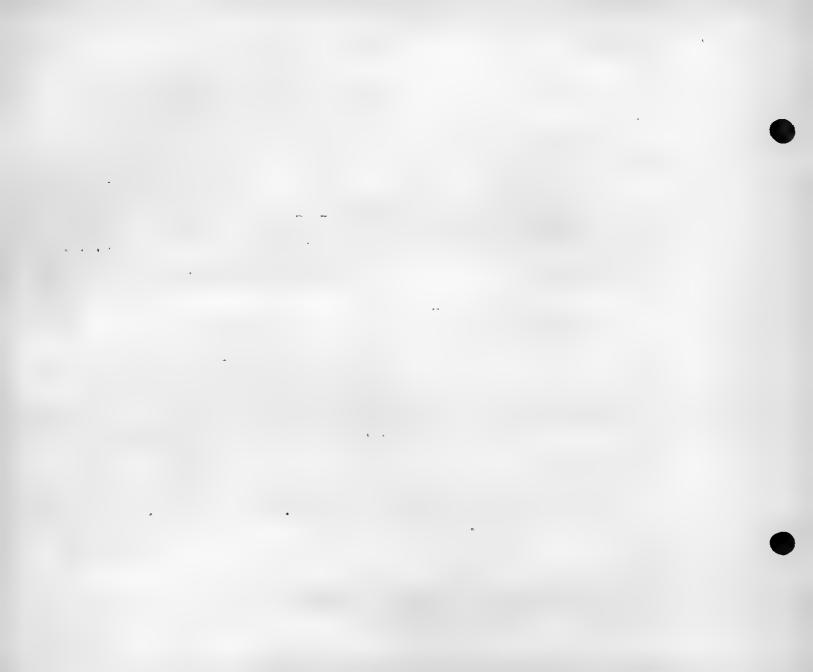
1	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12243 CERTIFICATE OF DEATH
nd 2 your	1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest fown) Carroll Carroll Carroll Carroll Colly OR TOWN (if outside corporate limits, write RURAL and give nearest fown)
s, Pages 1 appears after	New Windsor d. Name of Hospital or Institution (if not in hospital, give street address) College Ave. College Ave. New Windsor of Street address College Ave. Ves Institution (if not in hospital, give street address) College Ave. Ves Institution (if not in hospital, give street address) Ves Institution (if not in hospital, give street address)
omplete	3. NAME OF DECEASED (Type or print) Verna Mildred Hiteshew Day Vear OF DEATH 9 10 1967
carbon nt, yerh	5. SEX 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH 9. AGE (In years if UNDER 1 YEAR IF UNDER 24 HRS. last birthdey)
physician remove any ever	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary Office 11 BIRTHPLACE (County & State, or foreign country) Johnstown, Pa. U.S.A. 13. FATHER'S NAME
fending an please I, and in	Jacob C. Dailey 15. WAS DECEASED EVER IN U.S. ARMED FORCES? ; 16. SOCIAL SECURITY NO. 17. INFORMANT Address
d by the at permit. The	(Yes, no, or unkown) (Ifyesgive were relates of service) 196-09-0096 Roy L. Hiteshew New Windsor Md. 18. CRUSE OF DEATH [Enter only one cause per line for (e), (b), end (c), PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal CREINOMA COST. OCT. (c)
has been signe e burial-transit rial, cremation	Conditions, if any, which gave rise to immediate cause (a), staling the undarlying cause tast. DUE TO OUE TO OUE TO (b) A deno carcinoma of the Corving and Uterus (c)
rifficate as the or to bu	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
this ce ad for u	20a ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of Itom 18.) OR CONTRIBUTING CAUSE OF DEATH IT EITHER, NOTIFY MEDICAL EXAMINER)
tr. Afferdetacher.	20c. TIME OF INJURY Month, Day, Yeer Hour a.m. While Not While of work 19 work 19 work 19 While Not While of work 19 work 19 While Not While of work 19 work 1
ECTO	21. I certify that (I) (this hospital) attended the deceased from CCL1
the Sta	220 SIGNATURE ATTENDING MED. STAFF SIGNED ATTENDING DIRECTOR PHYS. 9 10 67
FUNER PRODUCT	220. PHYSICIAN'S NAME TYPE) J.H. CARICOTE 22d. APDRESS UNION BRIDGE, Md.
O P S	23a. BURIAL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) Burial 49/13/67 Pipe Creek Cometery Carroll Co. Md.
VR A15 (4)	24 UNERA DIRICTOR'S SIGNATURE ADDRESS NEW 250. REC'D BY REGISTRAR'S SIGNATURE DAGEP 1 3 1967 Pleases Judges



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12255 12244 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY CA o. STATE **b** COUNTY death. MARYLAND b CITY OR TOWN (If outside comparate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) wate RURAL and give nearest town CATONSVIII es TMINISTER d NAME OF HOSPITAL OR INSTITUTION (If not in nospital, give street address) d STREET ADDRESS e is RESIDENCE hours ON A FARM? Coleridge Rd CARROLI GENERA ote NAME OF 4 DATE Doy Year DECEASED Φ. OF (Type or print) DEATH S SEX 7 MARRIED NEVER MARRIED B. DATE OF BIRTH AGE (n years IF UNDER 1 YEAR JE UNDER 24 HRS and 2 Months Hours WIDOWED / Office 100 USUAL OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR (State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Housewife ony 13. FATHER'S NAME 14. MOTHER 5 MA DEN NAME ⊆ PURRICR 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) I(If yes give wor or dates of service removal. CHRISTY-Balto-18. CAUSE OF DEATH (Enter only one couse per line tos, (a), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY 0 IMMEDIATE CAUSE (o) word cremotian, DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO 0 stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS PERFORMED? 20o. EXTERNAL CAUSE WAS PRIMARY OF OF CONTRIBUTING CAUSE OF DEATH. Prior 3 should 20c. TIME OF NURY Month, Doy Year factory street (drice blog, etc.) of work of work 21. I certify that I taak charge of the remains described above, held an Autapsy Inspection : and in my apintan death resulted from: Accident X Suicide . Natural causes-Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE the funeral O DEPUTY DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health NAME (Type) Address breet on but or givery Buttomore BURIAL CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 0 REMOVAL (Specify) 9/27/6 CCH 24 FUNERAL DIRECTOR 301 Tres VR A15MEHS



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 72256 CERTIFICATE OF DEATH 12245 The law requires that the death certificate be executed within 24 haurs after death the attending physician and completely filled in by the funesate sit permit. Then please remave care papers. Pages I and 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission I. PLACE OF DEATH o. STATE o. COUNTY **b.** COUNTY CARROLL MARYLAND b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) Baltimore City SYKESVILLE MARYTAND mor 1 month B. IS RESIDENCE ON A FARM? d STREET ADDRESS Springfield State Hospital NO TO YES 2130 Dmid Hill Avenue 3. NAME OF Middle 4 DATE Eirst Day Year DECEASED (Type or pant) WALTER JONES DEATH September WAT.T.TAM IF UNDER 1 YEAR IE LINDER 24 HRS S SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In yeofs 7. MARRIED NEVER MARRIED last birthdoy) 88 yrs. Months Hours WIDOWED DIVORCED 6-15-79 Negro Male 10o, USUAL OCCUPATION (Give kind of work dane 12 CITIZEN OF WHAT 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or fareign country) during most of working life, even if retired)
Retired (Salesman INDUSTRY **COUNTRY?** II.S.A Virginia 14. MOTHER'S MAIDEN NAME 13 FATHER S NAME Munford Jones Martha Bridgeforth IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 216-36-7807 Hospital Files No 1B. CAUSE OF DEATH (Enter only one cause per line figr (a), (b), and (c).) INTERVAL BETWEEN burial-transit p burial, crematic ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Canditions, if any, which gave rise to immediate couse (o). DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been as the last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPS!
PERFORMED? CBS assoc. with senile brain disease with NO W Page 4 may be retained by the hospital or detached for 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) PSychotic 20o ACCIDENT WAS JNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) (County) (State) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, factory, street, office bldg., etc.) XENEXXX 19 6X to Sept. 4 19 67 that (1) (we) last 21. I certify that (I) (this haspital) ottended the deceased from sow the deceased olive on Sept. 4 67 and that death accurred at 12 A M, fram causes and an the date stated above. 19 22b. DATE SIGNED 22a. -SIGNATURE **ATTENDING** MED. DIRECTOR STAFF PHYS. M.D PHYS director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S Springfield State Hospital Ricio NAME (Type) NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o BURIAL CREMATION. (County) (State) REMOVAL (Specify). 25b REGISTRAR'S SIGNATURE 2Sg. REC'D BY REGISTRAR 1 charles VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH 16 1 7 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12246 12257 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death. pup PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed .ved, if institution Residence before admission) o STATE Maryland o COUNTY b. COUNTY filled in by the fund in papers. Pages 1 c Whin 72 haurs after d Carroll MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) L2vrs.6mos.2ldvs. Rural - Deer Park Sykesville d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d STREET ADDRESS Springfield State Hospital YES NO DE remaye Carbon r NAME OF Middle 4 DATE Lost Year completely DECEASED (Type or print) JAMES KIMMELL DEATH SEPTEMBER 19 67 IE UNDER 1 YEAR SEX IE UNDER 24 HRS 6 COLOR OR RACE DATE OF BIRTH AGE (In years 7 MARRIED NEVER MARRIED lost birthday) Months Dovs Hours 1904 White or removal, and in any Male WIDOWED DIVORCED and 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY **COUNTRY?** Maryland None US 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Sarah Hayne John Kimmell 15. WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no or unknown) (If yes give war or dates of service) burial-transit permit. burial, crematian, or r Records, Springfield State Hospital 18. CAUSE OF DEATH (Enter only one couse per line for (0), (b) and (t) PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN COSET AND DEATH signed by the burial-transit Aspiration Pneumonia IMMEDIATE CAUSE (a) Page 4 may be retained by the hospital ar attending physician. DUE TO Conditions, if any, which gove (b) rise to immediate cause (a). DUE TO stoting the underlying couse ifter this certificate has been be detached far use as the State Dept. af Health priar ta (c) 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) Schizophrenic reaction, simple type NO X OR ATTENDING PHYSICIAN: 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port il of item 18.) 20o ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Manth, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stole) Hour 'o.m. foctory, street, office bldg., etc.) Not While of work of work 21. I certify that (1) (this haspital) attended the deceased from 3-9-25 _, that (I) (we) last and that death occurred at 6:00 M. fram causes and an the date stated above saw the deceased alive an 9-30-67 TO FUNERAL DIRECTOR: 22b DATE SIGNED 22a, SIGNATURE ATTENDING X 10-3-67 M D Springfield State Hospital 22d ADDRESS 22c. PHYSICIAN'S Octavio A. Ruiz. M.D. Sykesville, Maryland 23d LOCATION (City of Lown) 230 BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR GREMATORY ((county) (Stote) 25b REGISTRAR'S SIGNATURE 250 REC'D BY REGISTRAR FUNERAL DIRECTOR VR A15 (4) 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the haspital ar attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached far use as the burial-transit permit. Then please, genave carbon papers. Pages returned be filed with the State Dept. of Health priar to burial, cremation, or remayals, and sevent, within 72 haurs affer the sould be filed with the State Dept. of Health priar to burial, cremation, or remayals, and sevent, within 72 haurs affer the

VR A15 (4) 25M 1/67

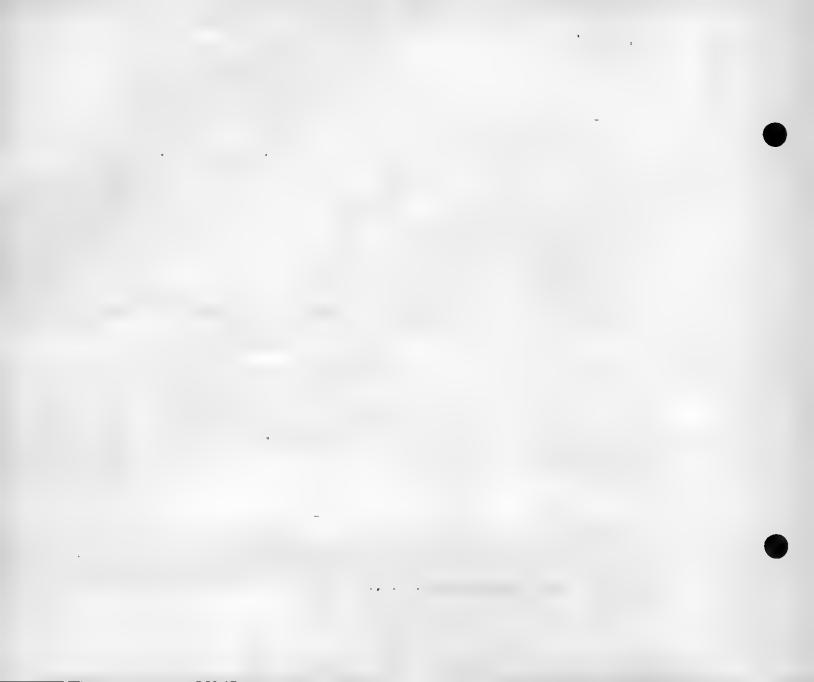
CERTIFICATE OF DEATH

	22.70.70 40 4							
	PLACE OF DEATH					Yhere deceosed lived, if i		ce before odmission)
(Carroll		MARYL	AND	o. STATE		COUNTY	
Į	CITY OR TOWN (If outside corporate limits,		E LENGTH OF STAY IN			tside corporate limits, wr	ite RURAL and give	neorest fown)
	write RURAL and give nearest town		09 D			,	5	
_	Sykesville, Maryland		28 Days		3325 Dolf	ield Ave. E	alto. 15	Md.
	S. NAME OF HOSPITAL OR INSTITUTION (If not in		,		d STREET ADDRESS			e IS RESIDENCE ON A FARM?
	Springfield State H	ospit	al					YES NO-
	NAME OF ANNA) AN First		Middle		Lost	4 DATE	Month	Doy Year
	Type or print) Annie Belle L	eake				OF DEATH S	ent. 2h	1967
4	EX 6 COLOR OR RACE 7	MARRIED	NEVER MARRIED	\Box	8 DATE OF BIRTH	9. AGE (In ye	eors IFUNDER	YEAR IF UNDER 24 HRS
		WIDOWED	DIVORCED	ΠI	h an am	last birthd	oy) Months T	Doys Hours Min
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	TATILE 3 HAME				14. MOTHER 3 MAIUEN P	IANIE		
_	Robert Moore				2			
S Yer	WAS DECEASED EVER IN U.S. ARMED FORCES? s, no, or unknown) (If yes give wor or dotes of se	16. !	SOCIAL SECURITY NO	17	INFORMANT		Address	
	No			H	ospital Reco	and -		
Ī	18. CAUSE OF DEATH (Enter only one couse	per line for	(o), (b), ond (c).)					INTERVAL BETWEEN
١	PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o)	(D)	neuma	rui.	a			ONSET AND DEATH
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	Conditions if any which gove a	0.0	Boon and	-M	otaxtatio	INDIANA	^	
I	rise to immediate couse (a), (A COLLEGE		Caraca	VVVV (Care	,	
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l	200 ACCIDENT WAS UNDERLYING []	20b DE:	SCRIBE HOW INJURY OC	CURRED.	(Enter noture of injury in I	Part I or Port II of item 1	8.)	
ŀ	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
i	20c. TIME OF NJURY Month, Doy, Year	20d 1N	IJRY OCCURRED		CE OF INJURY (Home, form		vn) (Cou	inty) (Stote)
l	Hour om.	While		for	ory, street, office bldg., etc.)			
ŀ	9111,	at work			8-28	9.67, to 9-21	10.6	57 45 4 15 / 15 /
1	21. I certify that (I) (this haspite saw the deceased alive an				t death accurred at			7, that (I) (we) las
ŀ	220 SIGNATURE	// i		nu mu	r deutir decorred di	ozacz m, nom co		TE SIGNED
- 1	220 SIGNATURE		K ///		ATTENDING -	MED. STAFF	220. 04	LEE SIGNED
1	Marido	- C	Muno	M	(1112)	DIRECTOR PHYS	9_2	24-67
l	22c PHYSICIAN S NAME (Type) On Tando C	YY			22d. ADDRESS	ili cit	Halay	L (°
Į	NAME (Type) Orlando C.	Ramos	3'/		1 Junger	ela Dieve	F105 M	6.1
	BUR AL CREMATION, 23b DATE THERE	OF .	23c NAME OF CEMET	ERY OR	CREMATORY	23d LOCATION (City	or Town)	(County) (Stote)
	REMOVAL (Specify)	7	1. Julia	2 //	and Tack	12 specle	w lite	-
4.	FUNERAL DIRECTOR	1	ADDRESS		25o. REC'D		5b. REGISTRAR'S SI	GNATURE
1	March 1 Glibble west	- 110	47/1/11/	42 /	MSFP	26	marco	27 Judge

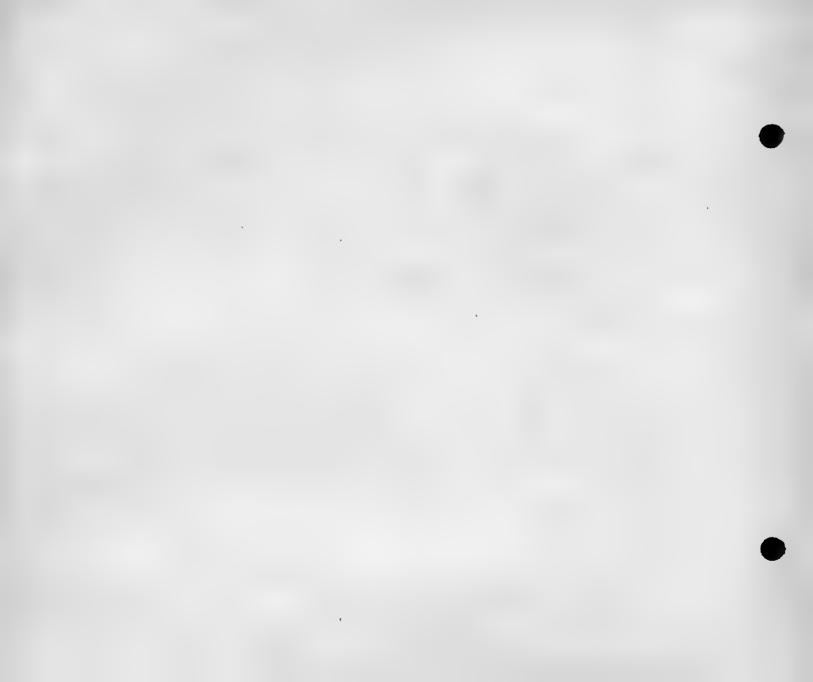


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 30 1. PLACE OF DEATH 8. COUNTY USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) COUNTY e remove carbon papers. Pages 1-I in any event, within 72 hours after MARYLAND b. CITY OR TOWN (if outside corporate limits c. LENGTH OF STAY IN 1b OR TOWN (If outside corporate limits, write RURAL and give nearest Write RURAL and filled d. NAME OF HOSPITAL OR IS RESIDENCE ON A FARM? TUTION (if not in hospital, give street address) d. STREET ADDR NO C executed within and completely NAME OF Middle First Month DECEASED 1962 (Type or print) SEX 6. COLOR OR AGE (in years | IF UNDER 1 YEAR last birthday) | Months | Days 5. 7. MARRIED 1 Hours WIDDWED DIVORCED 10a, USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) physician in please wal, and in or foreign country) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR INDUSTRY PLACE (County & State) The law requires that the death certificate be been signed by the attending phy the burial-transit permit. Then pl in to burial, cremation, or removal, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unkown) (If yes give war or dates of service) INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for ONSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a DUE TO Conditions, if any, which gave rise to immediate as the prior to DUE TO cause (a), stating underlying cause last. this certificate has CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? ed for use of Health p YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING OF CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 1) of Item 18.) **DIRECTOR:** After this certage 3 should be detached led with the State Dept. of MEDICAL TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Hour a.m. While Not While be retained by at work at work 21. I certify that (I) (this hospital) attended deceased from and that death occurred at 2.25 M. saw the deceased alive on from the causes and on the date stated above. SIGNATUR page ATTENDING PHYS. DIRECTOR M.D. Page 4 may TO FUNERAL 22c. PHYSICIAN'S director, p should be 1 22d. **ADDRESS** BURIAL, CREMATION, 23b DATE THEREOF 23c. (State) 23d. LOCATION (City, town or county) (Specify) **EUNERAL DIRECTOR** ADDRESS 25a. RECYD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 4-64





1			MARYLAND STATE DEPARTMENT OF HEALTH	
			DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, 1995() CERTIFICATE OF DEATH	MARYLAND
t TI		 _	and for first \$7.5	2261
aft.	4		PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased breed, if institution b. COUNTY b. COUNTY	Residence before admission)
a Carrie	ł		CARROLL (O MARYLAND MARYLAND OF	PRROLL C
4 7 2 2 2			with proper and first todatest (OAB)	ind give nearest town)
in 2 d in es 1		N	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS d. STREET ADDRESS	e. IS RESIDENCE
rag drs	OC			ON A FARM? YES PO NO
De de de	and the	3.	NAME OF PARK ROAD Middle Last 14. DATE Month	Dey Year
and and and	The same		DECEASED WALTER THOMAS LENTENER DEATH SET	16 19 67
6 S(5)		5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER	RT YEAR IF UNDER 24 HRS.
4 5 5	_		M WIDOWED DIVORCED SEPT 30, 1888, 78 yrs. Months	Days Hours Min.
fical ician ove		10a do	one during most of working life, even if retired)	TIZEN OF WHAT COUNTRY?
certi ihysi rem any		١,	ROOFING & PLUMBUG- SELF. EMPLOYED BALTO CO. MD.	USA
ng p ng p ease			title of a City of the city of	
andi andi		15.	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address C. D.O.	45 4000
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that it is		Ī	18. CRUSE OF DEATH [Enter only one cause per line for ,a), (b), and (c)]	INTERVAL BETWEEN
vires /sicie d by perm			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COCON	ONSET AND DEATH
Par Phy igne nsit			1538 DUE TO	
law ding en s en s f-tra			Conditions, if any, which (b)	
The then then s be surially cr			gava rise to immediate cause (a), stating the underlying DUE TO	
N: or a or a he b			Cause last. [c] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PA	27.1/2.10.2/4.5.4.1/7.025/Y
ital licate as t	1	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO BEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PA	PERFORMED?
rSI(hosp certif use rior	J.	FICA	20a ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of Item 18.)	YES NO T
PH the his c		GET	OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
Heal Heal		₹		ounty) (State)
Af Aff		MEDICAL	Hour a.m. While Not While factory, street, office bldg., etc.)	
TEN Telai De control			21. I certify that (I) (this hospital) attended the deceased from OCT	9.67, that (I) (we) last
Se S			saw the deceased alive on. SEPT. 151967., and that death occurred at 2.45M, from the causes and on	the date stated above;
			220 SIGNATURE LECTOR J. SCHOOL MAD. ATTENDING MAD. DIRECTOR DIRECTOR PHYS.	226, DATE
# 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			22c. PHYSICIAN S DIRECTOR PHYS. DIRECTOR PHYS. DIRECTOR PHYS.	9/16/67_
PIT Pag Vill			NAME (Type) 19 RIDGE RD. WESTMINS	The MB
HOSP ath. Pa FUNE ector, p	^	238	BURLAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or cou	1
V dio do	N		REMOVAL (Specify) 9/19/67 PROVIDENCE CEMETERS GAMBER CARR	
VR AIS (4)	M	24	EUNERAL DIRECTOR'S SIGNATURE ADDRESS 258. REC'D BY REGISTRAR 256. REGISTRAR	S SIGNATURE
15M 7/61	1/11/1	1	4. 5. Myers, p; Westminutes md. 21157 DATE SEP 19 1967 Police	Hes Judge :
	113	7-1		



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12251 12262 CERTIFICATE OF DEATH death. and USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY Maryland Baltimore The law requires that the death certificate be executed within 24 haurs after Carroll MARYLAND c CITY OR TOWN (if autside corparate limits, write RURAL and give nearest tawn) b CITY OR TOWN (If autside carporate amits, c. LENGTH OF STAY IN 16 write RJRAL and give nearest tawn) 1 month Owings Mills Westminster d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS B. IS RESIDENCE ON A FARM? 1.05 Ostmere Rd. Carroll County Ceneral Yosp. YES NO 17 3 NAME OF First Lost 4 DATE Manth Day Year DECEASED OF DEATH Taila Marie Long 19 (Type or print) IF UNDER 1 YEAR 9. AGE (In years IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7 MARRIED 8. DATE OF BIRTH **NEVER MARRIED** 7 ast birthday) Sept.10,1895 Months Hours White Female WIDOWED X DIVORCED 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 10a USJAL OCCUPATION (Give kind of work done COUNTRY 3 . A. during most of working life, even if retired)
Housewife INDUSTRY Balto. Co.. Md. 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Amelaa Wilhelm Joseph Corbin 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16, SOCIAL SECURITY NO. Oakmer e (Yes, na, ar unknown) (If yes give war ar dates of service) 218-32-02560 signed by the attendi Mrs. Posalie Caudill 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY. URFMIR IMMEDIATE CAUSE (a) .. DUE TO CHRONIC RENAL DISEASE Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been the WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) NO [RIDID YES | 205, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Doy, Year factory, street, office bidg , etc.) Not While at work attended the deceased fram 9/2, 1962, to 9/3, 1962, that (1) (we) last 9/2, 1967, and that death accurred at 132, M, from causes and on the date stated obove. 21. I certify that (I) (this haspital) attended the deceased fram_ saw the deceased alive on. 220_SIGNATURE 22b DATE SIGNED ATTENDING mans DIRECTOR 22d. ADDRESS 224- PHYSICIAN'S NAME (Type) director, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BJRIAL, CREMATION (County) (State) REMOVAL (Specify) Sept. 6, 1967 Jessops Com tery Baltimore Co. Md. 2Sb REGISTRAR'S SIGNATURE 2Sa. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR Manies Judge DATE SEP Owings Mills. Md. 20 M 1/66



BETTER BUSINESS FORMS, INC., BALTIMORE, MD. 2120 MARYLAND STATE DEPARTMENT OF HEALTH ISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH eath. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY Carroll Maryland Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages urs afte MARYI AND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b ģ on papers. Pag within 72 hours Sykesville, Md. Rural Years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) = Sykesville, d. STREET ADDRESS Md filled e. IS RESIDENCE ON A FARM? Lee Lane Lee Lane YES NOTE completely we carbon p executed within NAME DE First Middle Last DATE Month Day DECEASED evence (Type or print) Arthur DEATH vnch a 19 6. COLOR OR RACE | 7. MARRIED SEX AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS NEVER MARRIED and (last birthday) Months I Days Hours Male White WIDOWED DIVORCED | 8 Ξ. 102 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b, KIND OF BUSINESS OR 11. BIRT HPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? INDUSTRY Electrician:
13. FATHER'S NAME State Of Md. Maryland U.S.A. certificate removai. 14. MOTHER'S MAIDEN NAME Howard Lynch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? Alice Webster 16, SOCIAL SECURITY NO. 17. INFORMANT Address ō (Yes, no, or unkown) (If yes give war or dates of service) d by the at transit perm cremation, No Mrs. Mary Lynch-Sykesville. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN been signed the burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: [MMEDIATE CAUSE (a)] Congestive Heart Failure months The law requires Conditions, if any, which (b) Cardiomegaly same gave rise to immediate DUE TO cause (a), stating the as th prior (c) Myocarditis underlying cause last has same CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY this certificate the detached for use for use Health PERFORMED? NO TO YES F 2Da. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part | or Part |) of Item 18.) 2Dc. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2Df. (City or town) (State) (County) Hour a.m. After Not While at work at work retained 0 21. I certify that (I) (this hospital) attended the deceased from Jul 6 1902 to Sept 11 _ 19<u>67</u>, that (I) (we) last OIRECTOR: age 3 should led with the saw the deceased alive on Sept .19_67, and that death occurred at5: 304 from the causes and on the date stated above. 22a, SIGNATURE-22b. DATE SIGNED ATTENDING PHYS. STAFF PHYS. Sept 11 DIRECTOR Da FUNERAL PHYSICIAN'S 22d. ADDRESS or, g NAME (Txpe) Sani Rd. director Should b Okutman Obrecht Sykesville, Md. BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) Burial (Specify) Springfield Cemetery Sykesville Md. FUNERAL DIRECTOR ADDRESS VR A15 (4) DATE 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12253 12264 CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) Carroll a. STATE Maryland Baltimore_City MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn) 21-4 LOmos . 18dys . Sykesville Baltimore e IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? 400 Gold Street Springfield State Hospital NO K NAME OF First Middle Last 4. DATE Manth Year DECEASED MANNING SEPTEMBER 13 1967 FRED (NMN) (Type or print) DEATH SEX 6 COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH 9. AGE (In years IF JADER 1 YEAR IF UNDER 24 HRS NEVER MARRIED last birthday) Months Hours 6-8-16 Sep DIVORCED Male Negro WIDOWED 10g USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, at foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY South Carolina Laborer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME (1st name unk.) Paint John Manning 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, na, or unknown) (If yes give war or dates of service) 217-14-5244 Springfield State Hospital Records. Unak. NIERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) Days PART I. DEATH WAS CAUSED BY: Status epilepticus IMMEDIATE CAUSE (a). 501X DUE TO Canditians, if any, which gave Cerebrovascular accident Days rise ta immediate cause (a). DUE TO stating the underlying cause last. 19 WAS AUTOPS PART 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? CERTIFICATION NO IX 20g ACC DENT WAS UNDERLYING [1] 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MED CAL 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (State) 20c. TIME OF INJURY Month, Day, Year (County) Haur a.m. factory, street, affice blda., etc.) While Nat While at wark L 21. 1 certify that (1) (this haspital) attended the deceased from 10-25-66 19____, that (I) (we) las M. from causes and an the date stated above saw the deceased alive an 9-13-67 ____, and that death occurred at 19 22g. SIGNATURE 22b DATE SIGNED 9-13-67 M.D. PHYS PHYS 22d ADDRESS Springfield State Hospital 22c PHYSICIAN S NAME (Type) Sykesville, Maryland Octavio A. Ruiz. 23d LOCATION (City or Town) BURFAL CREMATION NAME OF CEMETERY OR CREMATORY ((aunty) (State) VAL (Specify) 24 FUNERAL DIRECTOR

TO FUNERAL DIRECTOR: director, page 3 should be filed v

OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death

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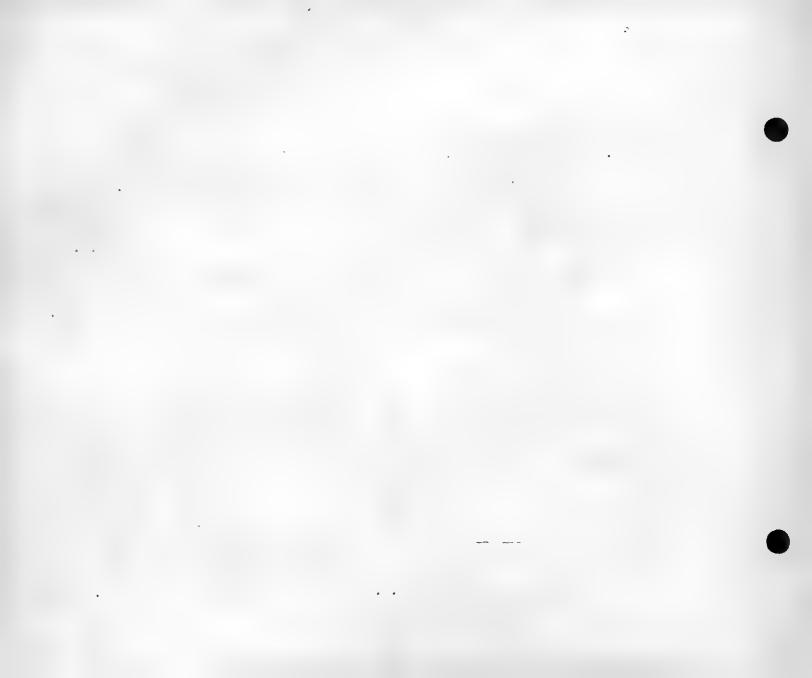
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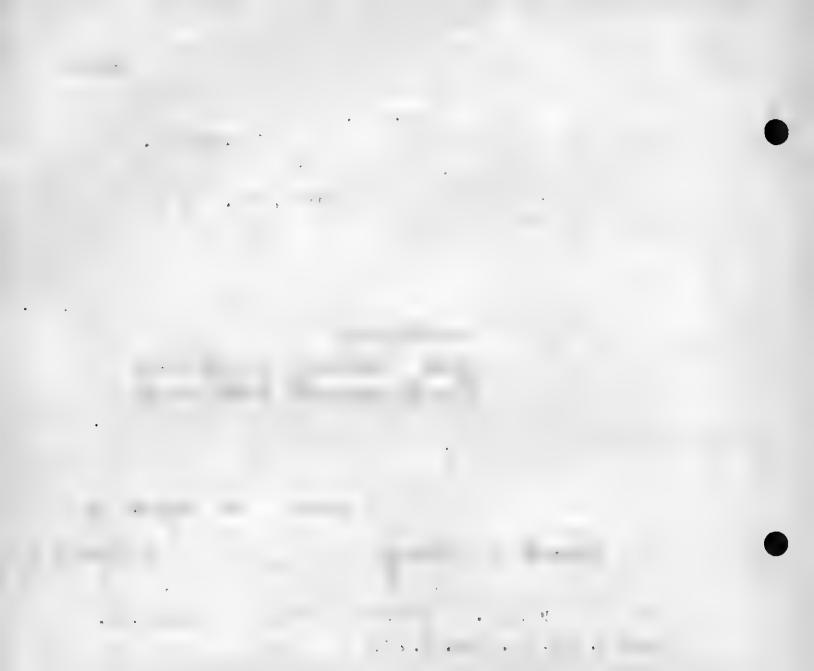
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12265 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR-STATE HEALTA DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o. COUNTY a. STATE a. b. COUNTY MARYLAND Carroll Mary land any delay the State Department b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) ang Westminster Westminster d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) e IS RESIDENCE ON A FARM? d STREET ADDRESS icate, writing the ward "pending" in pencil in Item 18. Give Pages 1, "be farwarded to the Chief Medical Examiner's Office along with farm Rd. #1 Westminster, Ma YES NO Rd. #1 Westminster, Md 24 haurs after death. NAME OF Midd e Lost 4 DATE Year DECEASED OF (Type or print) DEATH SAMILET MELVILLE NEVER MARRIED 6. COLOR OR RACE 7 MARRIED DATE OF BIRTH lost birthdoy) Months Doys eoth. WIDOWED DIVORCED [YTS YES pages land2 Mala White 106 KIND OF BUSINESS OR AL OCCUPATION (Give kind of work done 11 BIRTHPLACE (State or fore gn country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? ofter INDUSTRY Unk Maryland U.S.A 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within event within 72 hours Harry Melville Clark IS WAS DECEASED EVER IN L. S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service XOS 217-12-9230 Mrs Herman Mennerick 6513 Harrord Rd. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY ONSET AND DEATH Arteriosclerotic Cardiovascular Disease IMMED ATE CAUSE (o) This certificate shauld DUE TO burial in any Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse os o 19 WAS AUTOPSY PERFORMED? remayal, PART II. OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 8 NO E the certificate, CERT FICAT 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW NURY OCCURRED (Enter nature of njury in Port 1 of item 18.) shauld bluods Б PRIMARY I or CONTRIBUTING I CAUSE OF DEATH. crematian, 20d INJURY OCCURRED 20e PLACE OF NJURY (Home, form, 20c TIME OF INJURY Month, Day, Year (City or town) (County) (Stote) Hour a.m. foctory, street, office bldg., etc.) Not While may be retained far yaur FUNERAL DIRECTOR: Page of wark at work please execute 21. I certify that I tack charge of the remains described above, held an Autopsy Inspect on X. and in my opinion Inquiry death resulted fram: Natural causes (v). Accident Suicide Undetermined manner funeral directar Homic'de CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE M.D. DEPUTY MEDICAL EXAMINER **EXAMINER'S** Tealth . Russell S. Fisher, M.D. Address (Street, city, town, or county) NAME (Type) Sept. 27, 1967 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMAT ON 23d. LOCATION (City or Town) (County) REMOVAL (Specify) Sep. 29, 1967 Balto. Nat'l Cemetery Baltimore Maryland
GISTRAR 256 REGISTRAR 25 GNATURE 24 FUNERAL DIRECTOR 2So REC'D BY REGISTRAR VR ATSMETS 6M 1/67



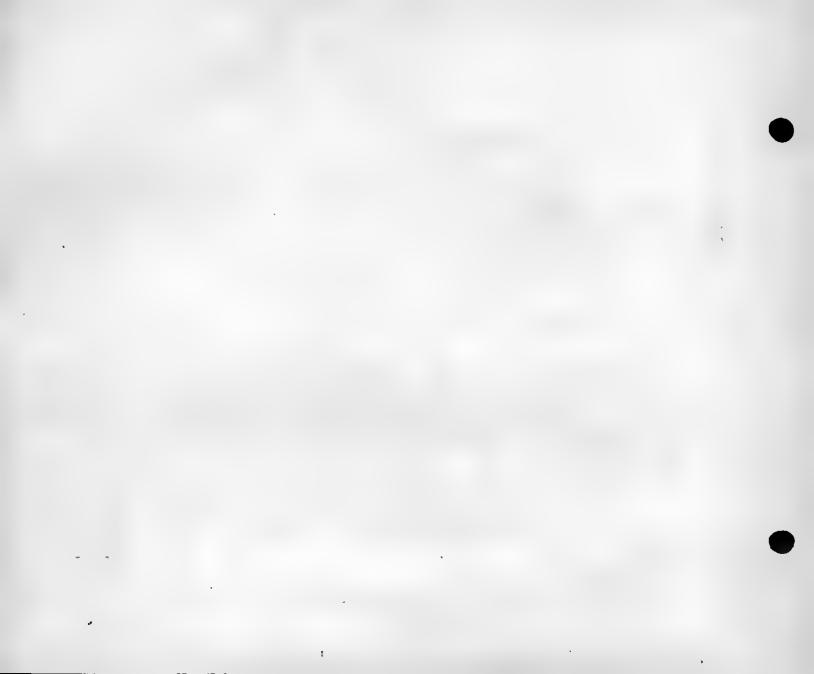
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쿹륵粪픋	E.	10.	CAUSE OF DEATH [Enter only on	e cause per line for (e), (b), end (e)	1.1			EVAL BETWEEN
Sicial P	0 1		PART I. DEATH WAS CAUSED BY:	Athenosolo	other Hand	Querin	UNSE	1 signer
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H 6 2 9	<u>&</u>	I ☑ OR	CONTRIBUTING CAUSE OF DEATH		,			
T	Hee .		c. TIME OF INJURY Month, Dey, Y		20e. PLACE OF INJURY (Home,	farm. 20f. (City or town)	(County)	(Siete)
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₹ 8 U B	9		w the deceased alive on	19	nd that death occurred at	M, from the caus	es and on the date	
(S	Š	22	o. SIGNATURE	4	ATTENDING	MED STAFF	1	22b. DATE SIGNED
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YR .	A15 (4) 18	24 10	TERAL DIRECTOR'S SIGNATURE	ADDRESS	-CINION 250.	REC'D BY REGISTRAR 256.	REGISTRAR'S SIGNATU	RE
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATEMARYLAND b. COUNTY PLACE OF DEATH a. COUNTY Carroll b. COUNTY TO COUR hours after MARYLAND filled in by the and cempletely filled in by the remove carbon papers. Pages any elect. Within 72 hours aff b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SYKESVILLE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b BALTIMORE CITY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8. IS RESIDENCE d. STREET ADORESS SPRINGFIELD STATE HOSPITAL 1518 Aisquith St. YES NO TC D HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Page 4 may be retained by the hospital or attending physician. 3. NAME OF Middle Last DATE Month Oay Year First 1967 DECEASED FRANCIS MORAN JR. 0. SEPT. Then please remove cari removal, and in any event DEATH (Type or print) AGE (In years | IFUNOER 1 YEAR | Months | Days IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE DATE OF BIRTH 9. NEVER MARRIED TX 7. MARRIED male 1906_ Hours August 5. DIVORCED WIDOWED 10a, USUAL OCCUPATION (Give kind of workdone during most of working life, even if retired) 10b, KIND OF BUSINESS OR UNDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT certificate has been signed by the attending physician hed for use as the burial-transit permit. Then please to of Reaith prior to burial, cremation, or removal, and in COUNTRY? none Baltimore City . Md. U.S.A. none 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME FRANCIS O. MORAN CATHERINE GEIS 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service) none MR. ARTHUR MARTIN 1506 AisquithSt. Balbb INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I, CEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (b) gave rise to immediate DUE TO vears cause (a), stating the underlying cause last. PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY CERTIFICATION FUNERAL DIRECTOR: After this certificate hirector, page 3 should be detached for use hould be filed with the State Dept. of Health p PERFORMEO? disorder with nsychotic reaction. convu YES NO DO deficiency 20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) MEDICAL (State) 20d. INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm. 20f. (City or town) (County) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. - Not While at work at work 21. I certify that (I) (this hospital) attended the deceased from M, from the causes and on the date stated above. and that death occurred at saw the deceased alive on DATE 22a, SIGNATURE STAFF PHYS. ATTENDING M.D. PHYS. DIRECTOR 22d, AOORESS PHYSIC!AN'S 22c. director, p NAME (Type) Mary (State NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) 23b. DATE THEREO BURIAL, CREMATION, 2 New Cathedral Cemetery Baltimore. 25a, REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto, Md. 21214 VR A15 (4) 15M 4-64



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 12268 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. physician and campletely filled in by the funeral non please, Pages 1 and aval, and incape every, within 72 hours after deat 1 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE b. COUNTY Carroll MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b Woodline d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Pullen Jursin YES 🗍 NO FE LOWE 3. NAME OF Middle Lost 4 DATE Month Dov Year DECEASED OF Ivy Pearre Type or print Scotember DEATH 9 AGE (In years IF UNDER 24 HRS S SEX 6 COLOR OR RACE IF JNDER 8. DATE OF BIRTH In any ev 7. MARRIED **NEVER MARRIED** (1) lost birthdoy) Months Davs Hours Female White WIDOWED TO DIVORCED 10o LSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Frederick Co., Md. Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attending physi burial-transit permit. Then pl burial, crematian, ar remaval, Edward E. Speake Julia V. Whilhide 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) Mr. J. Aubres Pearre 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c)) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY: Terminal Pneumonia IMMEDIATE CAUSE (o). DUE TO Conditions, if ony, which gove (b) Cerebral Emboli rise to immediate cause (o) DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been as the (a) Generalized Parkinsons Disease 10 years 19. WAS ALTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 3 shauld be detached for use with the State Dept. of Health YES | NO X Decubitus Ulcers Page 4 may be retained by the haspital ar 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Day, Year foctory, street, office bldg, etc.) Not While of work of work 2). I certify that (1) (this haspital) attended the deceased fram Aug 31 1967, ta Sept 29, 19 67 that (I) (we) last saw the deceased alive on Sent 16 1967, and that death accurred a8:30AM, from causes and an the date stated above. 22b. DATE SIGNED 22a. SIGNATURE ATTENDING DIRECTOR 22d, ADDRESS 22c. PHYSICIAN'S NAME (Type) Sani Okutman Obrecht Rd. Sykesville. director, 23b. DATE THEREOF 23c. NAME OF CEMETERY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION. (Stote) (County) REMOVAL (Specify) Toward Co., 250. REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR VR A15 ocharles 1967 20 M 1/2 Waltz 5 'resville, id.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12269 12258 CERTIFICATE OF DEATH deoth PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY Carroll County Maryland MARYLAND The law requires that the death certificate be executed within 24 hours after b. CITY OR TOWN (If autside carparate limits, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 wate RURAL and give nearest town) Bal timore .⊆ d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? filled Klee Mill Guest Home 2401 Calverton Heights Ave. YES -NO. 3 NAME OF Middle 4. DATE Year DECEASED OF DEATH Elizabeth and complete Supt. (Type or pant) 26 1967 5. SEX 6. COLOR OR RACE 9. AGE (n years IF UNDER 1 YEAR IF JNDER 24 HRS. 7. MARRIED DATE OF BIRTH **NEVER MARRIED** birthday) 7/13/1386 Manths Doys Hours Female White WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife 10b KIND OF BUSINESS OR 1). BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT please INDUSTRY **COUNTRY?** ottending physician sermit. Then please Pennsylvania 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME cremotion, or remayo Thomas Gallahgher D. Margaret Long 15. WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, na, ar unknown) (If yes give war ar dates at service liam same address 18 CAUSE OF DEATH (Enter on y one couse per lipe-far (a), (b) ond (c).)
PART I. DEATH WAS CAUSED BY.

1MMEDIATE CAUSE (a) INTERVAL BETWEEN buriol transit ONSET AND DEATH **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Poge 4 moy be retained by the haspital or attending physician. signed DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO as the prior to b stating the underlying couse this certificote hos been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS CERTIFICATION PERFORMED? NO 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of item 18) p to (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Haur o.m. factory, street, office bldg., etc.) Not While at work 21. I certify that (I) (this haspital), attended the desegsed fram ooge 3 should be sited the S and that death occurred at 6 / YSM, from causes and on the date stated above TO FUNERAL DIRECTOR: saw the deceased alive an 22a. SIGNATURE 22b. DATE SIGNED MED STAFF M.D. DIRECTOR PHYS. director, page should be filed 22c PHYSICIAN 22d. ADDRESS NAME (Type) 230 BURIAL CREMATION 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) (Stote) REMOVAL(Specify) Baltimora, Md. Loudon Park Comet 24. FUNERAL DIRECTOR REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4 25M 1/67



FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY a. STATE City Marvland Carroll MARYLAND funeral may be c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town) Baltimore Rural - Sykesville | 12vr 6 mo 7 da d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2yr 6 mo 7 da g) d. STREET ADDRESS 3 to 1 Springfield State Hospital Harlem Avenue NAME OF First Middle Last 4. DATE Month DECEASED DEATH MARY RAMSAY (Type or print) ELIZABETH after death, If a 3. Give Pages 1. ong with form I 5. SEX 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED NEVER MARRIED 2 with lest birthday) | Months | Days 78 WIDOWED TO 2-7-1889 Female Whi te DIVORCED l and c 1Da. USUAL OCCUPATION (Give kind of work done | 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) INDUSTRY -Marvland Housewife ges] any 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME <u>8</u>.E Helen Ramsav Levi Stiner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknwn) | (If yes give war or dates of service) executed within 2 iding" in pencil in permit. I Records, Springfield State Hospital 216-03-1454 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) burial-transit Bronchopnuemonia with multiple abscesses 7/6 X DUE TO Rheumatic and arteriosclerotic heart disease Conditions, if any, which EXAMINER: This certificate should be a certificate, writing the word "pen tould be forwarded to the Chief Med gave rise to immediate DUE TO cause (a), steting the used as a to burial, underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with senile brain disease with CERTIFICATION psychotic reaction external cause was the certificate, writing the should be forwarded to o be 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury in Part 1 or Part II of Item 18.) PRIMARY TO OF CONTRIBUTING TO CAUSE OF DEATH. 豆豆 3 shou agent, MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) Hour a.m. Not While please execute the certifical director. Page 4 should be for retained for your files.

TO FUNERAL DIRECTOR: Page 3 of Health or its designated at at work at work 21. I certify that I topk charge of the remains described above, held an Autopsy X. Inspection Inquiry Accident **Süicide** Homicide Undetermined manner death resulted from: Natural causes |x|, CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER SIGNATUR DEPUTY MEDICAL EXAMINER **EXAMINER'S** Porterfiel NAME (Type) Maurice G. Address (Street, city, town, or county) 23d. LOCATION (City, town or county) BURIAL CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 21 67 Western Balto. Hurial FUNERAL DIRECTOR 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE ADDRESS

VR ALSME (5)

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10

12. CITIZEN OF WHAT COUNTRY?

USA

e. IS RESIDENCE ON A FARM?

YES NO X

Year

19 67

Hours

INTERVAL BETWEEN

WAS AUTOPSY

PERFORMED?

and in my opinion

22. DATE SIGNED

(State)

NO

(State)

CAVE AND DEATH

vears.

YES .

(County)

L.C.



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 12271 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY b. COUNTY Carroll Carroll Maryl and MARYLAND b. CITY OR TOWN (if outside corporate limits, E. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) davs Westminster Taneytown d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Carroll County General Hospital George Street YES NO X 3. NAME OF Middle 4. DATE DECEASED (Type or print) DEATH September 23, Reindollar, Sr. Henry 6. COLOR OR RACE 7, MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years IF UNDER I YEAR ! IF UNDER 24 HRS. last birthday) Months | Days WIDOWED [DIVORCED | May 12,1885 Male White 10a. JSUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. B RTHPLACE [County & State, or foreign country] 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S.A. Retail merchant Hardware store Marvland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Milton Henry Reindollar Laura Williams 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) | (If yes give war or dates of service) Mrs. Isabella Reindollar, Taneytown, Maryland 213-14-4481 18. CAUSE OF DEATH |Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO atterescluste short Disease Conditions, Fany, which gave rise to immediate cause DUE TO (e), stating the underlying causa last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CATION PERFORMED? 20a. ACCIDENT WAS JNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20a, PLACE OF INJURY (Homa, form, 20f. (City or town) (State) (County) lectory, street, office blog., atc.) While Not While Hour a.m. at work at work 21. | certify that (1) (this hospital) attended the deceased from 250201..... 1967 to 1967, that (1) (we) last 2.3,......19.6.3, and that death occured at 1.32M, from the causes and on the date stated above saw the deceased alive on. 22a. SIGNATURE DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S FUNERA FUNERA rector, page NAME (Type) NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23b, DATE THEREOF 23d, LOCATION (City, lown or county) (Stata) REMOVAL (Specify) O.A Sept. 26.1967 Burial Lutheran Cemetery Tanevtown Maryland 24 FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE

certificate

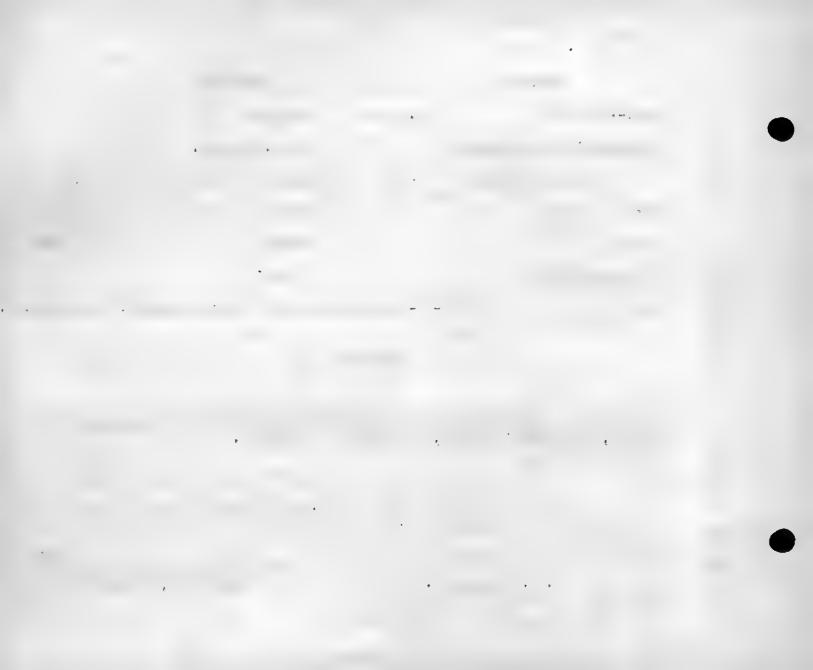
DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 12272 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. STATE Nd. o. COUNTY b. COUNTY MARYLAND b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn) write RURAL and give negrest lawn) undon PHYSICIAN: The law requires that the death certificate be executed within 24 haur d. STREET ADDRESS d. NAME OF HOSP.TAL OR INSTITUTION (If not in hospital, give street oddress) ON A FARM? Central Ave. ounty General Hospital YES NO campletely fi NAME OF Middle 4 DATE Month First Day Year DECEASED Renshaw OF DEATH 67 September 19 (Type ar print) IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX & COLOR OR RACE DATE OF BIRTH AGE (In years 7. MARRIED **NEVER MARRIED** lost birthday) Months Hours Male August 8. WIDOWED DIVORCED Vna ni bua E C 11. BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT 10a USLAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR physician a during most of working life, even if retired) COUNTRY? INDUSTRY Baltimore 10 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attending physic burial-transit permit. Then pl burial, crematian, ar removal, Richard L. Renshaw Mary Meredith IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na, ar unknown) (If yes give war or dates of service) Mr. Richard L. Renshaw None INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Canditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse the prior to has been last. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED CONDITION GIVEN IN PART 1(a) CERTIFICATION be detached for use State Dept. of Health YES -NO by the haspital ar O FUNERAL DIRECTOR: After this certificate 200. ACCIDENT WAS UNDERLYING 205, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Hame, form, 20f. (City or town) (Stote) 20d INJURY OCCURRED (County) TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Not While at work at work 21. I certify that (I) (this cospital) attended the deceased fram 15-13-6 ~2 . 19:- ∠, that (I) (₩£) lost 19 4 2, ta Page 4 may be retained director, page 3 shauld should be filed with the 1967, and that death occurred at 5 4 M, from causes and on the date stoted above -22 saw the deceased alive on_ 22b. DATE SIGNED 22a. SIGNATURE STAFF M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23g BURIAL, CREMATION, 23b. DATE THEREOF (County) (State) REMOVAL (Specify) Evergreen Memorial Sept. 23 Finksburg ADDRESS 2Sq. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATURE **VR A15** ine & Sons Reisterstown. Md.



1	Divi	isian of STATISTIC/		ARYLAND STATE DE CH AND RECORDS, 30		<mark>HEALTH</mark> IREET, BALTIMORE, MAI	RYLAND 2120	01
	12262	•		CERTIFICATE	OF DEATH		1227	3
1	PLACE OF DEATH o. COUNTY	Carroll		MARYLAND	n STATE	E (Where deceased lived, if ins b. (nitution Residence	a before admission)
F	b CITY OR TOWN (If or write RURAL and give	tside corporate limits, e negrest town)		The 2days	COTY OR TOWN (III	outside corporate limits, write	RURAL and give	nearest town)
	d NAME OF HOSPITAL O	R INSTITUTION (If not in		street oddress)	d STREET ADDRESS			e IS RESIDENCE ON A FARM?
	pringfield NAME OF A	State Hosp	1tal_	Middle	702 5 •	23rd St.	Aanth	VES NO TO
	DECEASED (Type or print)	etta Selet	ia	Maud	Rickard	OF DEATH	9	18 19 67
			MARRIED T	NEVER MARRIED DIVORCED	3/22/17	9. AGE (In year	s IF UNDER 1	YEAR IF UNDER 24 HRS. Doys Hours Min.
10	usual occupation (Givering most of working life,	e kind of work done		OF BUSINESS OR STRY		nty & State, or foreign country)	12. C Ti	ZEN OF WHAT
13	FATHER'S NAME				14. MOTHER'S MAID			JUA
	George Por	nder			Anna			
15	. WAS DECEASED EVER IN es, no, or unknown) (If y	U.S. ARMED FORCES? es give war or dates of se	16. SOC		INFORMANT	Hospital rece	ddress	kaswilla Md
	Canditians, if ony, whi rise to immediate co stating the underlyin lost	inmediate cause (a). Due to ch gove (b). g couse (c). (c)	Thremb	osis left co	lerosis			INTERVAL BETWEEN ONSET AND DEATH MITTULES YEARS
CERTIFICATION		ntington g DERLY NG D AUSE OF DEATH	Charman	. with namh	atte meant	CONDITION C VEN IN PART I (o T UNKNOWN OF 100 In Port I or Port II of item 18.		19 WAS AUTOPSY PERFORMED? YES NO
MEDICAL	20c. TIME OF INJURY Hour o.m. p.m.		20d INJUI While of work	Not While foot	CE OF INJURY (Hame, ory, street, office bldg.,	etc.)		
		that 🗱 (this hospite	al) attended 19/18/	the deceased from	2/16/ t death accurred	, 19. 67 , to 9/ at/12 PM, fram caus	L8/ , 19 _6 ses and an th	
	220. SIGNATORE	Dimoi	K	M.		MED. STAFF DIRECTOR PHYS.	4	TE SIGNED 9/18/67
	220. PHYSICIAN S NAME (Type)	H. E. Con	mor, J	r.	22d. ADDRESS	Springfield Sykeaville,	State E Marylan	iospital
	O BURIAL, CREMATION, REMOVAL (Specify)	Sept. 22	167	23c NAME OF CEMETERY OR MALLY CALLY C	ry Cem	23d LOCATION (City of		(Caunty) (State)
	4. FUNERAL DIRECTOR	hikem	112971	Carline.	//	SEP 2 0 1967	registrones sin	Pag Qued "





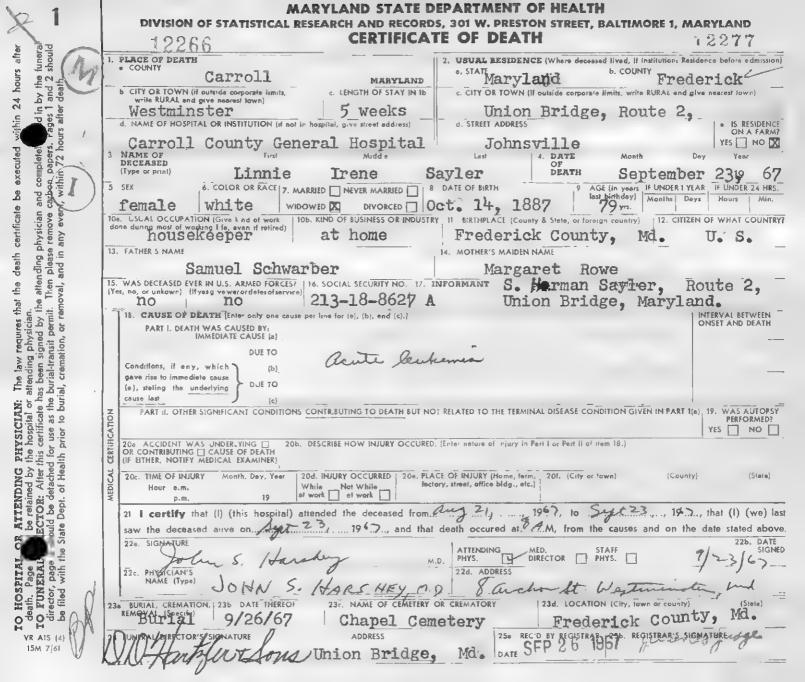
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE. MARYLAND 21201 12264 CERTIFICATE OF DEATH 12275 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased leved, if institution Residence before admission) a. COUNTY o STATE Marvland b. COUNTY Montgomery Carroll MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, t. LENGTH OF STAY IN 1b. write RURAL and give nearest town) OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours - Sykesville vr. 9 mo. Bethesda d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? 9 filled 7016 Exfair Rd. Springfield State Hospital YES NO S 3. NAME OF Middle 4. DATE 1 Lost Month Dov Year campletely DECEASED (Type or print) ROSS DEATH September 17 COL CHLBERTSON WHITFIELD SEX 9. AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE 7 MARRIED TE B. DATE OF BIRTH IF JNDER 24 HRS NEVER MARRIED last birthday) Months Days 06-08-04 Male White WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) **COUNTRY?** INDUSTRY Hydraulic Engineer
13. FATHER'S NAME Michigan USA 14. MOTHER'S MAIDEN NAME remayal, Lester V. Ross Catherine West 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give wor or dates of service] 16. SOCIAL SECURITY NO 17 INFORMANT 5 Records. Springfield State Hospital unk INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE (AUSE (a) Bilateral bronchopneumonia Davs DUE TO aspirated vomitus Conditions, if ony, which gove (b) Perforated abdominal aneursym Davs rise to immediate couse (a), DUE TO arteriosclerosis stoting the underlying couse by the haspital ar attending 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)

Chronic brain syndrome, presentle brain dis ase with psychotic reaction YES DOC NO 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (Stote) (County) 윷 Hour om factory, street, office bldg., etc.) While Not While ot work L ot work O FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased fram 12-17, 1963, to 9-17, 1967, that (1) (we) last saw the deceased alive an 9-17, 1967, and that death occurred an 19:00PM, fram causes and an the date stated above be retained 22o. SIGNATURE 22b. DATE SIGNED ATTENDING 9-18-67 X director, page 3 shauld be filed v MLĐ DIRECTOR 22c. PHYSICIAN S 22d ADDRESS Springfield State Hospital NAME (Type) Octavio A. Ruiz Sykesville, Maryland 21784 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230 BURIAL, CREMATION, (Stote) (Соилту) REMOVAL (Specify) 9/19/67 Cremation Cedar Hill Suitland. Faryland 25b. REGISTRAR S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS 25o, REC'D BY REGISTRAR Funeral Home-1331 Rockville VR A15 (4) 25M 1/67 Rockville. Maryland



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12265 12276 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admiss of) o. COUNTY arroll o. STAMarvland b. COUNTY MARYLAND b CITY OR TOWN (If outside carparate limits, c LENGTH OF STAY IN 15 c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) Sykesville Baltimore 7Yrs.hlits. d STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RESIDENCE ON A FARM? filled 808 St. Paul St. Springfield State Hospital NAME OF First Middle 4 DATE Year DECEASED Maude 1067 Rowe Sept. (Type or pnnt) DEATH 6. COLOR OR RACE 2 MARRIED 8. DATE OF BIRTH AGE (In years IF JNDER YEAR IF UNDER 24 HRS NEVER MARRIED last pythday) White 9-4-79 Female WIDOWED DIVORCED 10a USJAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CIT ZEN OF WHAT 11. BIRTHPLACE (County & State or foreign country) during most of working life, even if retired) HouseWile Own Home Virginia 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Minnick, Margaret S. Lilly, George W 15 WAS DECEASED EVER IN L. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 109-18-9108JI Records, Spring Field State Hospital 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN PHISEL AND DEATH Congestive Heart Failure IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave (b) rise to immediate cause (o), DUE TO stating the underlying cause certificate has been WAS AUTOPSY PERFORMED? PAR DIFFERENCE TO THE CONTROL OF THE DIFFERENCE OF THE PROPER OF THE OFFICE OFFICE OF THE OFFICE OFFICE OFFICE OF THE OFFICE OFF With Psychotic Reaction. 20o ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) Haur a.m. factory, street, affice bldg., etc.) Not While 21. I certify that (N (this haspital) attended the deceased fram 4-5-60 saw the deceased alive an 9-8-67 19 , and that death ac and that death accurred at III:05% from causes and an the date stated above TO FUNERAL DIRECTOR: 22a SIGNATURE 22b. DATE SIGNED MED DIRECTOR STAFF PHYS directar, page 3 shauld be filed v M.D 22c PHYSICIAN'S NAME (Type) Paul G.Ensor, M.D Springfield State Hosp. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL CREMATION. (County) (State) REMOVAL (Specify)
Burial Elkridge. Md. /1967 Melville M.E.Cemetery 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd. 2So REC'D BY REGISTRAR 2Sb. REGISTRAR S SIGNATURE VR A15 (4) 25M 1/67 DATE SEP 13 1967 Balto.12, Md.







3	1	Division of STATISTICAL F		PARTMENT OF HEALTH 1 W. PRESTON STREET, BALTIMORE,	MARYLANI	21201
FOR STATE			MEDICAL EXAMINER'S			12278
HEALTH DEPT.		LACE OF DEATH COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceased fived, a STATE Maryland	if institution R b. COUNTY	esidence before admission) Carroll
T. 2, old Train m PM. Train of Department of rs ofter death.		CITY OR TOWN (foutside corporate imits, write RURAL and give nearest tawn) Sykcsville	c length of stay N ib	COLLY OR TOWN (If outs de carporate limits, Sykesville	write RURAL o	nd give nearest tawn) O (a) /
Solution of the solution of th		NAME OF HOSPITAL OR INSTITUTION (IF not in hasp Springfield State Ho	spital	d street address 17 Walnut Avenue		e IS RESIDENCE ON A FARM? YES NO S
2 ST - 2		NAME OF SECASED SEBERT	JOHNSON S	LEMP 4 DATE OF DEATH	Month -	Day Year 7 1967
2 - 0 - 27 =		M White WHO		8 DATE OF 818TH 9. AGE (IIII) 9. AGE (IIII) 9. AGE (IIIII) 9. AGE (IIIII) 9. AGE (IIIIIII) 9. AGE (IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		nths Days Hours Min
	dur	FATHER'S NAME DON'T OF THE PROPERTY OF THE BUTCH OF THE	INDUSTRY REPRESENTED TO THE PROPERTY OF THE PR	Virginia 14. MOTHER'S MAIDEN NAME		COUNTRY? USA
H will will be Exar	15.	Andrew J. Slamp WAS DEFFASED EVER IN U.S. ARMED FORESS	1 16 SOCIAL SECURITY NO. 17	Arranda	Address	
xecute nding: Medicol permit. movol,	(Ye	(if yes give war ar dates of service) 10 18 CAUSE OF DEATH (Enter only one cause per lii	R	ecords, Springfield S	tate Ho	INTERVAL BETWEEN
icote should bing the ward ded to the Chinas o buriol-tron I, cremotian, or		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 34 / DUE TO	Right heart failu	re ntricular inferction	of the	days and Death
5 5 5 4	CATION	PART II OTHER'S GNIFICANT CONDITIONS CONTRIBU	TING TO DEATH BUT NOT RELATED TO	THE TERMINAL D SEASE CONDITION GIVEN IN PAI	(† 1(a)	19 WAS AUTOPSY PERFORMED? YES NO
The state of the s	AL CERTIFICATION	PRIMARY Or CONTRIBUTING CAUSE OF DEATH		(Enter noture of injury in Part I or Port II of its		
XAMIII ute the age 4 s your f Your f oge 3	MEDICAL	Hour a m. p.m. 19	While hat While for	ory, street, office bldg , etc.)	r town)	(County) (Stote)
nessary, please execut e funeral director. Pog may be retained far y FUNERAL DIRECTOR: Realth or its designated		21. I certify that I took charge of the death resulted from Natural couse			, Inquiry nined manne	
Ple de la constant de		EXAMINER'S V. Glenn Spote	Mer, M.D.	M.D ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER AUTOST STORE THE AU	v) A l	9/26/67
TO DEPUTY Hereta to be	230	BURIAL, CREMATION, 23b DATE THEREOF PREMOVAL (Specify) 9-29-67	230 NAME OF CEMETERY OR 5/emp Cem	CREMATORY 230 LOCATION	City & Tawn)	ster ma
VR A15ME (5)	7/2	JANERAL DIRECTOR Haight -	Sylcesville, Mid	2SG. REC'D BY REGISTRAR DATO CT 4 1967	25b REGISTR	ars signature



MARYLAND STATE DEPARTMENT OF HEALTH Gertificate of Death 12279 physician and campletely filled in by the funeral en please remave carbon papers. Pages 1 and 2 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death afterdeath 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY, o. COUNTY MARYLAND ELENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RLRAL and give nearest tawn) Carlisle 10vrs9mo2da d STREET ADDRESS IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Coholity/Honde Springfield State Hospital YES KE NO [NAME OF Middle 4 DATE First Month DECEASED (Type or print) 19 67 AMOS MMN. 9 DEATH IF UNDER 1 YEAR IF LINDER 24 HRS SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years 7 MARRIED NEVER MARRIED 12/27/1894 White WIDOWED DIVORCED Male 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 10b KIND OF BUSINESS OR 10a USUA, OCCUPATION (Give kind of work done during most of working ite, even if retired) COUNTRY? INDUSTRY Washington Co. Maryland 14 MOTHER'S MAIDEN NAME 13. FATHER 5 NAME Frank Slichter Clara Reed 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO 17. INFORMANT Address 220-54-6018 Hospital Records CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c).
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH burial-transit Heart failure IMMEDIATE CAUSE (o). DUE TO signed Conditions, if ony, which gove Arteriosclerotic heart disease Years rise to immediate couse (o), DUF TO stoting the underlying couse as the TO FUNERAL DIRECTOR: After this certificate has been Days Bronchopneumonia 19. WAS AUTOPSY PERFORMED? PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Mental defective, undifferentiated (Microcephaly) YES FE NO Page 4 may be retained by the hospital ar 百 200 ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, form, (Stote) 20d. INJURY OCCURRED (City or town) (County) 20t. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour o.m. Not While of work of work 21. I certify that (I) (this hospital) attended the deceased from 12/12/56 . 19 ____, 19____, that (I) (we) last 19 . and that death accurred at 8:30 M, fram causes and an the date stated above saw the deceased alive on 9/14/67 22b DATE SIGNED 22o SIGNATURE MED DIRECTOR STAFF PHYS. **ATTENDING** 9/11/67 director, page 3 should be filed v M.D. PHYS Springfield State Hosnital 22c. PHYSICIAN'S NAME (Type) Rafi Iqbal, M.D. 23o. BURIAL TREMATION, REMOVAL (Specify) MAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) 23bz DATE THEREOF (County) 25g. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24. PLINERAL DIRECTOR DATE SEP 20

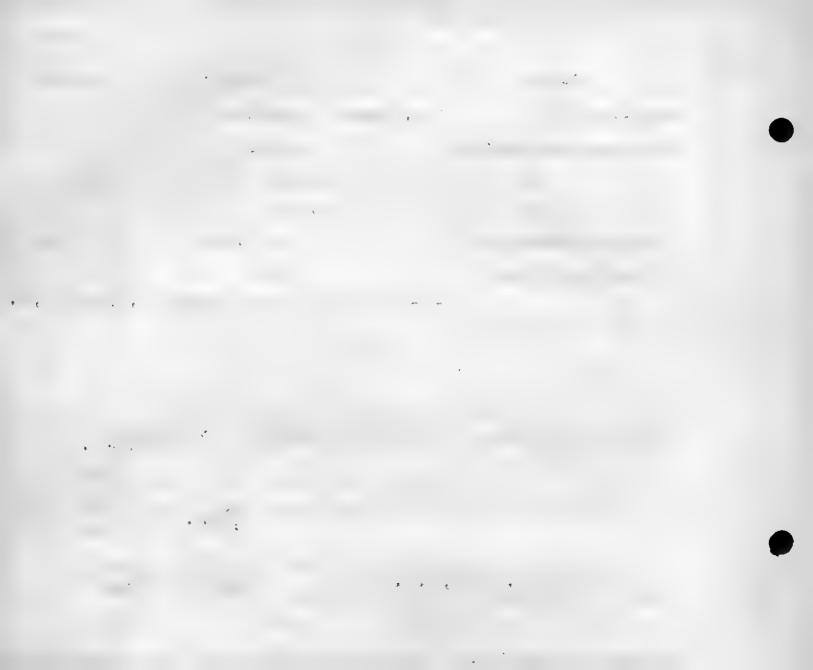


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12280 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death physician and completely filled in by the funeral on please remove carbon papers. Pages I and USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY o STATE b. COUNTY Carroll Marvland MARYLAND Carroll b CITY OR TOWN (If autside corporate imits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If auts de carparate limits, write RURAL and give nearest town) write RURAL and give nearest town) Tanevtown Taneytown d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 65 York Street 65 York Street YES 🗔 NO X NAME OF Firs! Middle Lost 4 DATE Month Day DECEASED Stambaugh (Type or print) Ohler September Maude DEATH AGE (In years lost birthday) SEX IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH Manths Days Hours WIDOWED DIVORCED March 23. Female White 10o USUA, OCCUPATION (Give kind of work dane 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY Housewife Frederick County, Maryland
14. MOTHER'S MAIDEN NAME U.S.A Own home 13. FATHER'S NAME signed by the attending phy hurial-transit permit. Then Anna G. Shorb John T. Ohler INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, ar unknown) (If yes give wor or dotes of service Mrs. Otis Shoemaker. Taneytown, Md. R.D. 218_2/._9039 18. CAUSE OF DEATH (Enter only one couse per line for loth (b), and (c) PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN IMMEDIATE CAUSE (o) DUE TO Canditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying couse the has been 19. WAS AUTOPSY PERFORMED? OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THIS JERMINAL DISEASE CONDITION GIVEN IN PART 1(a) O FUNERAL DIRECTOR: After this certificate far 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part 11 of item 18.) be retained by the haspital 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) Hour o.m. Not While factory, street, office bldg , etc.) at work at work 21 I certify that (I) (this haspital) attended the deceased from , 1967, that (I) (we) last . to 1967, and that death accurred of 130B. M. from causes and on the date stated above saw the deceased alive on, 22o. SIGNATURE 22b DATE SIGNED ATTENDING M.D. DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, plnods 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (State) REMOVAL (Specify) Keysville Cemetery Keysville, Carroll, J 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Marvland 24 FUNERAL DIRECTOR DATEC Taneytown, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 12281 12270 law requires that the death certificate be executed within 24 hours after death and USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. STATE Maryland o. COUNTY b. COUNTY Carroll MARYLAND c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 write RURAL and give nearest town) New Windsor Rural DOA Westminster the attending physician and campletely filled in by sit permit. Then please remave carbon papers d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e IS RESIDENC ON A FARM? Hawks Hill Road General Hospital YES NO X Middle 4. DATE 3 NAME OF Lost Month Year DECEASED OF Leslie Staub. 19 67 (Type or print) Pau] DEATH IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 9 AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH last birthdoy) Months Hours WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & Store, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Laborer-Md. S INDUSTRY COUNTRY? A. Roads Commission Frederick Co., Md. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Effie Smith Charles F. Staub TS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address R (Yes, no, or unknown) (If yes give wor or dotes of service) 214-1406898 Elsie S. Staub New Windsor, Md. No INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) DUE 10 Conditions, if ony, which gove rise to immediate cause (a), DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been the lest. 19 WAS AUTOPSY PERFORMED? PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION far use YES 🗌 NO X 205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED foctory, street, office bldg., etc.) Not While . 19____, ta_ , 19___, that (I) (we) last 2). I certify that (1) (this haspital) attended the deceased fram. and that death accurred at M, fram causes and an the date stated above saw the deceased alive an 22b. DATE SIGNED 220. SIGNATURE **ATTENDING** DIRECTOR director, page 3 should be filed v 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Westminster. Md. Wilkens Reese 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County) (Stote) 230. BURIAL CREMATION MEADOW BRANCH (EMETERY ESTMINSTER 2Sb. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Clientes VR A15 (4) DATSEP 20 M 1/66





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12282 12271 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAM: The low requires that the death certificate be executed within 24 hours ofter death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) 子の一 a. COUNTY o. STATE b. COUNTY Carroll MARYLAND Maryland Maryland Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 15 filled in by th papers. Pag hin 72 hours c Silver Spring Rural - Sykesville vr. 19 da d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 11636 Lockwood Drive Springfield State Hospital NO x YES 3. NAME OF 4 DATE carbon int, with Middle Lost Year DECEASED STINE WILLIAM September 15 (Type or pont) ROSS **OEATH** IF JNOER I YEAR S SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS 7. MARRIEO NEVER MARRIED lost birthdoy) Months Doys Hours Male White WIDOWED DIVORCED 1-24-1892 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? STORE 13. FATHER'S NAME Kanawha Co., W. Virginia IISA 14. MOTHER'S MAIDEN NAME removal, Ross W. Stine Virginia Cracraft 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, na, arunknown) (If yes give war ar dates of service) Records. Springfield State Hospital 18. CAUSE OF OEATH (Enter only one cause per line far (a), (b), ond (c).)
PART 1. DEATH WAS CAUSED BY: INTERVAL SETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) the hospital or attending physician. **CUE TO** Conditions, if any, which gave 3 nse to immediate cause (a), DUE TO stating the underlying cause this certificate hos been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. DISFASE CONDITION GIVEN IN PART, I(a) 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part L at Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Hame, farm, 20d INJJRY OCCURRED 20c TIME OF IN JRY Month, Day, Year (City or town) (County) (State) factory, street, affice bldg., etc.) After at work 21. I certify that (%) (this hospital) attended the deceased from Angust 26., 19.66, to Sept. 15, 19.67, that (b) (we) last be retoined 19_67, and that death accurred all: 15PM, from couses and on the date stated above TO FUNERAL DIRECTUR: saw the deceased alive an Sent 22b. DATE SIGNED SIGNATURE 9-15-67 director, page 3 should be filed v M.D. DIRECTOR PHYS HYSICIAN'S 22d. ADDRESS > pringfield State Hospital NAME (Type) Agustin del Campo Sykesville, Maryland 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23a. BURIAL CREMATION. 23b DATE THEREOF (County) (State) REMOVAL (Specify) Kingwood, West Virginia Maplewood Cemetery 25a REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE



ARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 12283 I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before edmission) e. COUNTY **b.** COUNTY Carroll Marvland MARYLAND b. CITY OR TOWN (if outside corporata limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) write RURAL and give nearast town) .57 Union Bridge Union Bridge vears d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO Broadway 21 W. Broadway complete NAME OF 4. DATE Middle DECEASED (Type or print) DEATH Oscar William Strawsburg 19 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED 5. SEX 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS Pue last birthday) Months | 3 VIDOWED [DIVORCED 10s. USUAL OCCUPATION (Giva kind of work 1Db. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY! done during most of working life, even if retired) farmer laborer Frederick Co. Md. U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John W. Strawsburg Elizabeth Harris 15. WAS DECEASED EYER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) | (If yes give war or dates of service) Edith D. Strawsburg Union Bridge, 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] INTERVAL BETWEEN INSET AND DEATH PART I. DEATH WAS CAUSED BY: ORONAN nous IMMEDIATE CAUSE (e) Conditions, if any, which geve rise lo immediata causa DUE TO (a), stelling the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY CERTIFICATION PERFORMED? 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of injury in Pert I or Pert II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH WEDICAL 20c. TIME OF INJURY 2Dd. INJURY OCCURRED . 20e. PLACE OF INJURY (Home, ferm. (Stefa) Month, Day, Yeer 2Df. (City or town) (County) factory, street, office bldg., etc.) White Not While Hour a.m. et work et work 21. I certify that (I) (this hospital) attended the deceased from....... 7., 19....., that (I) (we) last M, from the causes and on the date stated above. saw the deceased alive on ...19, and that death occurred at 22b. DATE 228 STGNATOR **ATTENDING** SIGNED PHYS. DIRECTOR ALD. FUNERA Union Caricofe Bridge, Md. director, be filed 23e. BURIAL, CREMATION. | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) O Pipe Creek Cemeterv Carroll UNION 256, REC'D BY REGISTRAR 256, REGISTRAR'S SIGNATURE FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** VR AIS



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12273 CERTIFICATE OF DEATH 12284 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institut on Residence before admiss on) o. COUNTY o. STAT Maryland b. COUNTY filled in by the fund papers. Pages 1 of hin 72 hours after d ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after Carroll MARYLAND c CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 1h write RURAL and give nearest town)
Sykewville Baltimore lv.3m.7d. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? filled The Alamedae E Springfield State Hospital YES NO T NAME OF Middle 4 DATE Month Year ove tekbon Lost Dov campletely DECEASED September 19 67 Arthur Herbert Sturgeon event, (Type or pant) 9. AGE (n years IF UNDER 24 HRS S SEX 6. COLOR OR RACE 7 MARRIED 8. DATE OF BIRTH **NEVER MARRIED** birthdoy) Months Hours Dovs 5-30-88 Male White WIDOWED DIVORCED ond in only rem ond 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

DT1 CKM2501 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT physician a Retired COUNTRY? Maryland USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remayal. Emma Douglas George Sturgeon I by the attending partransit permit. The Hecords INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? Springfield State Hospital, Sykesville, Md. World. War 1 Yes, no, or unknown) INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).) signed by the burial-transit purial-transit purial-transition ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Acute Heart Failure dave DUE TO Bilateral pneumonitis Conditions, if any, which gove days rise to immediate cause (a), DUF TO stoting the underlying couse as the has been Arteriosclerotic cardiovascular disease vears PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAI DISEASE CONDITION GIVEN IN PART 1(0).

Chronic brain syndrome associated with senile brain disease with psychotic reaction. WAS ALTOPSY PERFORMED? NO To certificate 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port H of item 18.) 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CITCAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (Stote) 20c TIME OF INJURY Month, Dov. Year (City or town) (County) Hour om factory street, office bldg, etc.) Not While of work 1966 9-7-1967, that (I) (we) los 21. I certify that (1) (this haspital) attended the deceased from 2-11-. to be retained 19 67 TO FUNERAL DIRECTOR: sow the deceosed olive on , and that death accurred at6: 20 pM, from causes and on the date stated above 220 SIGNAPURE 22b DATE SIGNED 9-7-67 X director, page 3 M.D. Springfield State Hospital PHYSICIAN ' O HOSPITAL NAME (Type) Carlos G. Lavin, M. D. Sykesville, Md. 23d LOCATION (City or Town) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION (County) REMOVAL (Specify)
Burial Baltimore National Baltimore Ma Cen 24 FUNERAL DIRECTOR 250 REC D BY REGISTRAR VR A15 (4) 25M 1/67 SANDER & SONS. INC. Baltimore Md.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 1227 CERTIFICATE OF DEATH 12285 puo 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY CO. CARROLL CITY OR TOWN (If outside exparate limits, write RURAL and give nearest tawn) MARYLAND b CITY OR TOWN (If autside carparate limits, CLENGTH OF STAY IN 16 write RURAL and give nearest town) WESTMINSTER MESTMINS TER | 60 M The law requires that the death certificate be executed within 24 hou d STREET ADDRESS e IS RESIDENCE ON A FARM? 228 PENNA AUE. CARROLL CO. NO Z NAME OF Middle 4. DATE First Month pllysician and completely DECEASED (Type or print) DEATH 9 AGE (In years SEX IF LINDER I YEAR 7. MARRIED NEVER MARRIED гетоуе (yobittid tea. MALE AUG: 27 19 DIVORCED WIDOWED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 1) BIRTHPLACE (county & State or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired)

MASTER MECHANIC INDUSTRY COUNTRY? FLOOR COVERING PLANT MESTMINS 4.5.0 13. FATHER'S NAME L, CLARK TAYLOR MARY AGNES KNIG 17 INFORMANT 16 SOCIAL SECURITY NO. (Yes, na, ar unknown) (If yes give war ar dates of service INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),) buriol-tra≡sit ONSET AND DEATH PART ! DEATH WAS CAUSED BY-ARDIAC IMMEDIATE CAUSE (a) DUE TO MYOCAKDIAL INFARCTION Conditions, if any, which gave 1 rise to immediate couse (a), DUE TO stating the underlying cause TO FUNERAL DIFFICTOR: After this certificate has been the RTERIOSCLEROTIC HEBET PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) PERFORMED? use YES NO F fa 20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 1B.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, form) (City or town) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (County) (State) factory, street, affice bldg., etc.) Hour a.m. Nat While . 1962 ta______, 19___, that (i) (we) iasi at 1/556 M, from causes and on the date stated above. 21. I certify that (1) (this haspital) attended the deceased from be retained 1967, and that death accurred at 1/5 saw the deceased alive on 22a. SIGNATURE 22b. DATE SIGNED DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, bluods 23g BURIAL, CREMATION, 23c NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 23d LOCATION (City or Town) LEISTERS CEMETERY RURAL, WESTMINSTER REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12286 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. COUNTY b COUNTY MARYLAND b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 write RURAL and give pearest town). write RURAL and give represt town e IS RESIDENCE ON A FARM? NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) YES NO TX NAME OF Middle First DATE Month DECEASED OF DEATH mes 1967 Type or print) burial-transit permit. Then please remove ca burial, cremation, ar remaval, and in any event SEX AGE (In Veors IF JNDER IF UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED **NEVER MARRIED** lost birthdoy) Months Dovs Hours WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if refired)

LADDRER INDUSTRY uland LUMBER 13. FATHER'S NAME 14. MOTHER'S MAIDEN 16 SOCIAL SECURITY NO. (Yes, no_ogunknown) (If yes give wor or dotes of service) 216-14-5703 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH PART I DEATH WAS CAUSED BY-Coronary thrombosis, acute: Cardiac failure: IMMEDIATE CAUSE (o) DUE TO March 1967 Conditions, if ony, which gove through Emphysema: Arteriosclerosis, generalized: rise to immediate cause (a), 9/4/67 DUE TO stoting the underlying couse has been the with arteriosclerotic heart disease. 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. DISEASE CONDITION GIVEN IN PART I(o) YES F NO 🔀 TO FUNERAL DIRECTOR: After this certificate O HOSPITAL OR ATTENDING PHYSICIAN: 20o ACCIDENT WAS JNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port | or Port |) of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF the JRY Month, Doy, Year Hour Jo.m. 2Dd INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) Not While ot work ot work 2) I certify that (I) (this haspital) attended the deceased from March 1967 to 9/4/ saw the deceased alive an Sept. 4, 19 67, and that death accurred at 7:30 Mafram causes and an the date stated above 22o SIGNATURE 22b. DATE SIGNED STAFF PHYS director, page 3 shauld be filed w 9/5/67 M.D DIRECTOR 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Howard E. Hall. M.D. Sykesville, Maryland BURIAL CREMATION. DATE THEREOF (County) REMOVAL (Specify) FUNERAL DIRECTOR 250 REOD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12287 12275 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) p. COUNTY b. COUNTY Carroll Maryland Frederick MARYLAND b CITY OR TOWN (If outside corporate limits, c CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b write RURAL and give nearest town)

Sykesville 13 days Thurmonto 21788 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? d STREET ADDRESS Springfield State Hospital 22 Church Street NO DE YES NAME OF Middle 4 DATE First Day Year DECEASED OF DEATH Frank Jeraldo TORTORO September 24. 1967 (Type or print) S SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 8. DATE OF BIRTH 7 MARRIED **NEVER MARRIED** last birthday) Mnaths Hours 11-18-1891 WIDOWED T male white DIVORCED 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)

Stonecutter Grave COUNTRY? Stones Italy Naturalized 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Blase Tortoro - dec. Annotolte Trotta - dec. 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates af service) 16. SOCIAL SECURITY NO. 17. INFORMANT 213-01-3121-A Springfield State Hospital Records 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH Congestive heart failure. IMMEDIATE CAUSE (a) DUF TO Conditions, if only, which gave nse ta immediate cause (a), DUE TO stating the underlying cause 19 WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO x 20a ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form 20c TIME OF INJURY Manth, Day, Year Haur o.m. (City or fown) (County) (State) factory, street, office bldg, etc.) Not While at work L at wark 2]. I certify that (\$\frac{1}{2}\$ (this hospital) attended the deceased fram ______9/1] 1967, that (I) (we) last 19**67**, ta 9/24 19.67, and that death accurred at 2:30 12 from causes and an the date stated above saw the deceased glive an 220 SIGNATURE 22b. DATE SIGNED STAFE **ATTENDING** MED DIRECTOR X 9/24/67 22c PHYSICIAN'S 22d ADDRESS Springfield State Hospital Sykesyille, Maryland 21784 NAME (Type) Naci a. Buyukunsal. M.D 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23c BURIAL, CREMATION, (County) BENDAN (Specify) Holy Redeemer Cem. Baltimore City, Md. 9-27-67

Cream

barmond E.

2Sb. REGISTRAR S SIGNATURE

25a, REC'D BY REGISTRAR

TO FUNERAL DIRECTOR: After director, VR A15 [4]

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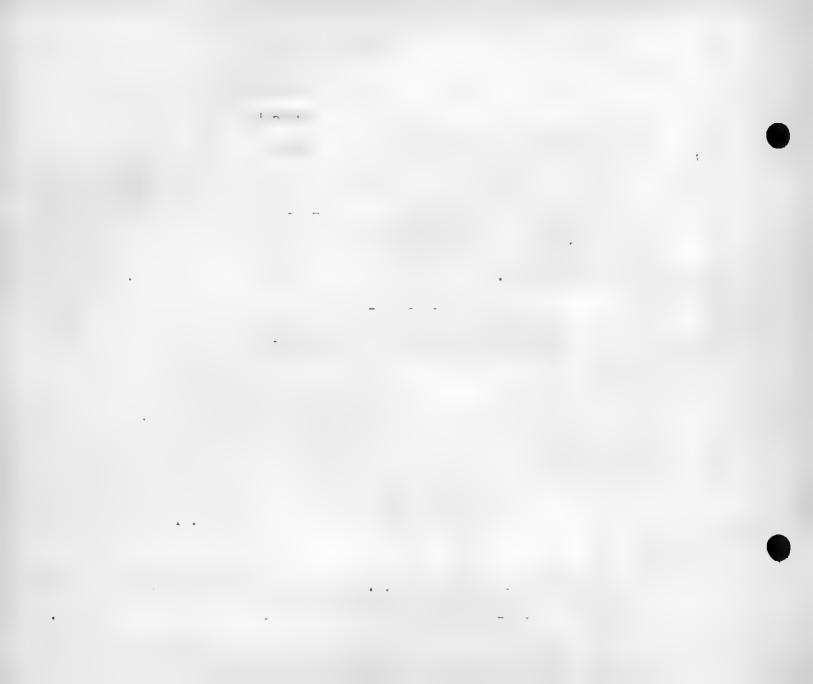
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OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death

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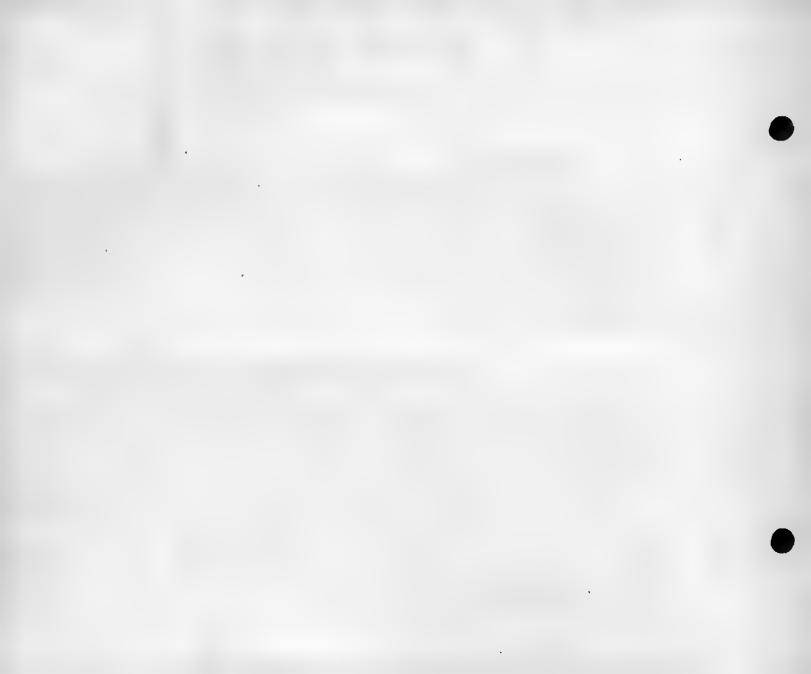
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× 1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201							
	12275 CERTIFICATE OF	1 2 5 6 6						
fer death funeral s j and 2	o. COUNTY Carroll MARYLAND	USUAL RESIDENCE (Where deceosed lived, if institution Residence before odm ssign b. COUNTY Baltol-Cit	- promote and a second					
by the Page	write RURAL and give nearest town) Sykesville 3mos.	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 21234						
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death estained by the haspital or attending physician. CTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral shauld be detached far use as the burial-transit permit. Then please remove carbon papers. Pages I and 2 shauld be detached far use as the burial, crematian, ar remaval, and in any event. Within 72 haurs after death in the State Dept. at Health priar to burial, crematian, ar remaval, and in any event.	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) Springfield State Hospital	STREET ADDRESS 2915 Oakcreat Avenue 8. IS RESIDED ON A FAIL	ENCE RM2 NO XX					
	3 NAME OF First Middle DECEASED (Type or print) Helen Voern	VENIII TO THE TOTAL THE TOTAL TO THE TOTAL TOTAL TO THE T	67					
	Female White WIDOWED X DIVORCED 1-	ATE OF BIRTH 9. AGE (n yeors FUNDER YEAR IF UNDER 1. Specific Sp	Min.					
te be (ian anica a	100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11.	1. BIRTHPLACE (County & Stote, or foreign country) Bermany 12 CITIZEN OF WHAT COUNTRY? U.S.A.						
tifica hysic n ple val, a		MOTHER'S MAIDEN NAME						
death cer tending p rmit. The		unk RMANT Medical Record Address ngfield Hospital, Sykesville, Md.	_					
The law requires that the death certificate be executed vattending physician. In the speed physician and camplete has been signed by the attending physician and camplete as as the burial-transit permit. Then please remove cart the priar ta burial, crematian, ar remaval, and in any execut.	18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE (AUSE (o) Asphyxia DUE TO occlusion of bronchi Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause lost. Output Due To occlusion of bronchi (b) Alzheimer's Disease of Due To (c)	by milk. INTERVAL BETV ONSET AND DE	tes					
DING PHYSICIAN: The law reby the haspital or attending lifer this certificate has been be detached far use as the State Dept, af Health priar ta	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TE Chronic Brain Syndrome associated with psychotic reaction.	ith canabacl automicael anothe resturne	PSY D? NO					
DING PHYSICIAI by the haspital frer this certifice be detached far State Dept, af He	20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19 While at work at work (1997)	street, office bldg., etc.)	Stote)					
	220. SIGNATURE R. Eyning, mo M.D. A	ne 16 , 19 67 to Septemb2219 67 that (M (verth occurred at 2:25 M, from causes and an the date stated ATTENDING MED. STAFF MED. OURECTOR PHYS MED 9-22-67 22d. ADDRESS Springfield Hospital	we) last abave.					
TO HOSPITAL OR Page 4 may be r TO FUNERAL DIRE director, page 3 should be filed w	230 BURIAL CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATED PARKWOOD 24. FUNERAL DIRECTOR ADDRESS	Baltimore Co. 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	ote)					
VR A15 (4)	P. A. Heemann 6067 Harford Rd.	DASED 26 1967 20 20 20 20 20 20 20 20 20 20 20 20 20						



I	tems 20c&21 Film 393 MARYLAND STATE DEPARTMENT OF HEALTH ソーレンーも? admision of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
IOR STATE	12279 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
HEALTH DEPT.	PLACE OF DEATH o. COUNTY Carroll MARYLAND 2 USUAL RESIDENCE (Where deceosed lived if institution Residence before odmission) b. COUNTY Maryland Maryland Vashington					
th If any delay is ges 1, 2, and 3 to h farm PM3. Page, tote Department of hours after death.	b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) write RURAL and give nearest tawn) C ENGTH OF STAY IN 16 C CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)					
If Siny arm P. 2, 2, orm P. 1, 2, or after	d NAME OF HOSP TAL OR INSTITUT ON (If not in hospitol, give street address) d. STREET ADDRESS e. S. RES. DENCE ON A FARM?					
death Pages with fo	Springfield State Hospital 400 Brookline Ave. 3. NAME OF DECEASED Fish Middle Last 4 DATE Month Doy Year Of					
after de 8. Give along w	(Type or point) JOHN THOMAS WADE, JR. DEATH SEPTEMBER 13 9 67 S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years IF UNDER 14 ARS IN 15 U					
th n 24 haurs encil in Item 18 miner's Office o pages land 2 in any event	100 USUAL OCCUPAT ON (Give kind of work done during most of working life, even if refired) 10 USUAL OCCUPAT ON (Give kind of work done during most of working life, even if refired) 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY?					
th in 24 incil in miner's pages in any	Carpenter New York U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Delia M. Thorne					
red with the period of the per	15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service)					
execulending Medic	No 216-30-2952 Records, Springfield State Hospital INTERVAL BETWEEN INTERVAL BETW					
uld be and 'p e Chiel al-trans	MMMEDIATE CAUSE (c) ASDRIVATA 141-1 DUE TO					
MEDICAL EXAMINER: This certificate shauld be executed with n 24 haurs after death 1f any delay is please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to director. Page 4 shauld be farwarded to the Chief Medical Examiner's Office along with farm PM3. Page, estained for your files. DIRECTOR: Page 3 should be used as a burial-transit permit. File pages Tand 2 with the Nate Department of its designated agent, prior to burial, cremation, or remaval, and in any event within 72 maurs after death.	Conditions, if ony, which gove isse to immediate couse (a), stating the underlying couse (b) Occlusion of larynx by food Minutes					
certifice, writing arwarde used as burial,	Dest. Cc PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUT NOT DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19 WAS AUTOPSY PERFORMED? P					
This ificate, d be found to be controlled by the controlled be controlled by the controlled be controlled by the controlled by	Throlutional psychotic reaction PERFORMED? YES INC NO					
AINER: The certifice I should be should be a should be a should be a should be a should be then, prior	20c TIME OF N. JRY Month, Day Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form, 20f (City or fown) (County) (State)					
L EXAM Recute the Page 4 or your R. Page atted age	21. I certify that I took charge of the remains described above, held an Autopsy . Inspection . Inquiry . and in my apinian					
Medical EXAMINER: This please execute the certificate of director. Page 4 shauld be frequent for your files. L DIRECTOR: Page 3 should be its designated agent, prior ta	death resulted fram: Natural causes Accident 2d, Suicide , Homicide , Undetermined monner					
o DEPUTY MEDICA necessary, please ex the funeral director. 5 may be retained 7 FUNERAL DIRECTOR	SIGNATURE SIGNATURE SIGNATURE SIGNATURE ASS STANT MEDICAL EXAMINER DEPUTY MED CAL EXAMINER 9-13-67					
TO DEPUTY MEACAL EXAM necessary, please execute the funeral director. Page 4 5 may be retained for your TO FUNERAL DIRECTOR: Page >Health or its designated age	NAME (Type) W. Glenn Speicher, M. D. Add Free Try My occupy 230. BUR AL CREMATION, 236 DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (Ly or Town) (County) (Siote)					
VR ATSME (S)	PONYA TREET 9-16-67 Cedar Lawn Mem. Park Hagerstown Town Signature 24. FUNERAL DESS 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MINDION TO THE PROPERTY OF THE PROPER					
6M 1/66	Minnich Funeral Home, Hagerstown, Nd. orgp 18 1967 Charles Judge					



	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTO CERTIFICATE OF DEATH	N STREET, BALTIMORE 1, MARYLAI
1.	e. COUNTY CARROLL CO. MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if	E (Where deceased lived, If Institution, Residence before b. COUNTY PROLL i outside Exports limits, write RURAL and give nearest
-	write RURAL and give nearest town? WESTMINSTER RD# 4 79 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	STER ROHY
3	(REESE) 3. NAME OF DECEASED (Type or print) ELLA NORMA WARD	4. DATE Month Day OF DEATH SEPT. 27
10	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH FEMALE WHITE WIDOWED DIVORCED JAN. 25 18 106. USUAL OCCUPATION (Give kind of work 106. KIND OF BUSINESS OR INDUSTRY IT BIRTHPLACE (County)	9. AGE (In years IF UNDER 1 YEAR IF UNDER 1
0	HOUSE - WIFE 3. FATHER'S NAME CARROLL 14. MOTHER'S MAIDEN N	CO.MD. Hisia
1. ()	JOHNATHAN MONATH ELLEN 1. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no., or unknown) (Ifyesgivewarordetesofservice) 217 05 18808 MR. EDGAR	Address SAME R. WARD ADDRESS
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Conditions, if eny, which gave rise to immediate cause (a), stating the underlying couse last.	- acute Min
CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMIN. 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	PE YES
MEDICAL	Hour e.m. 19 White Not White Pactory, sires, office bidg., etc.)	1 A 1 27 17
	saw the deceased alive on	19 G7 to Harles All 19 Se. (that (I PM), from the causes and on the date state (IRECTOR PHYS. [] 9-27-
		23d, LOCATION (City, lown or county)



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE DE DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) after Jarrell ar d MARYLAND b. CITY OR JOWN (if outside corporate limits, write BURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENCTH OF STAY IN 1b. à hours Chevy Chase kesville 5 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET AODRESS ON A FARM? 203 Primrose Street No 🖂 within completely Wit NAME OF First Middle Last 4. DATE Month Day DECEASED Mathewson (Type or print) DEATH 19 executed SEX 6. COLOR OR RACE 7. MARRIEO NEVER MARRIED DATE OF BIRTH ACE (In years IF UNDER I YEAR last birthday) Months | Oays F UNDER 24 HRS and c Hours WIDOWED K DIVORGED [10a. USUAL DCCUPATION (Cive kind of work done | 10b. KIND OF BUSINESS OR 11. BIRT HPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Washington, D. C. S. liousewife 13. FATHER'S NAME removal. 14. MOTHER'S MAIDEN NAME Helen Mathewson Allison C. Jenkins 15. WAS DECEASED EVER IN U.S. ARMED FORCES? d by the attend transit permit. cremation, or n 16. SOCIAL SECURITYNO 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service) Same as Item No Nursing Home records 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] INTERVAL BETWEEN been signed by the burial-transit or to burial, crem? ONSET AND DEATH PART I. DEATH WAS CAUSED BY: tending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT WAS AUTDPSY his certificate hetached for use Dept. of Realth for use Health PERFOR MED? CERTIFICAT ND E YES [20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING OCCUPATION CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME DF INJURY Month, Oay, Year 20d. INJURY OCCURRED | 20e, PLACE OF INJURY (Home, farm,) 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. After While Not While at work at work DIRECTOR: At age 3 should lied with the S 21. I certify that (I) (this hospital) aftended the deceased from Zand that death occurred at 1/G.M. from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE 22b. DATE SICNED page ATTENDING M.O. DIRECTOR PHYS. PHYS. HOSPITAL TO FUNERAL PHYSICIAN'S 22d. ADDRESS director, p NAME (Type) 23a. BURIAL, CREMATION, NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) Cedar Hill Cremation Crematory Suitland. Harvland 25a. HEC'D BY REGISTRAR 125b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ethesda, Maryland

VR A15 (4) \ 20M I/65 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12282 12293 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE MARYLAND b CITY OR TOWN (If outside carparate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAs and give negrest tawn) d. NAME OF HOSPITATION INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? Liberty Libertu NO X YES NAME OF Middle Day Year DECEASED (Type or print) OF DEATH 19 burial, cremation, or remaval, and in any event, requires that the death certificate be executed 7. MARRIED DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS NEVER MARRIED lost, birthday) Manths Days Hours WIDOWED DIVORCED OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) Secretary 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME CONA 16 SOCIAL SECURITY NO. 17 INFORMANT (If yes give war or dates of service) 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEATH PART I DEATH WAS CAUSED BY Cardiac failure, renal failure, IMMEDIATE CAUSE (a) DUE TO 1964 Conditions, if ony, which gove Bronchial pneumonia. through rise to immediate cause (o), DUE TO 9/27/67 stoting the underlying cause Severe emphysema and anemia. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? Health NO N ATTENDING PHYSICIAN: 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) factory, street, affice bldg , etc.) of work of work 21 I certify that (I) (this haspital) attended the deceased fram____ 1964 to Sept. 27, 19 67, that (I) (we) las director, page 3 shauld should be filed with the saw the deceased glive an Sept. 27, 19 67, and that death occurred at 5:30 M, fram causes and on the date stated above TO FUNERAL DIRECTOR: 22a SIGNATURE 226 DATE SIGNED ATTENDING STAFF PHYS. Sept. 28,167 DIRECTOR M.D. PHYS 22d ADDRESS 22c. PHYSIC AN'S NAME (Type) Sukesville, Maryland Howard E. Hall, M.D. direct (Stote) BURIAL, CREMATION (County) REMOVAL (Specify) UTIAL FUNERAL DIRECTOR VR A15 (4)

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MARYLAND STATE DEPARTMENT OF HEALTH

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